COMPREHENSIVE PERFORMANCE REPORT:

COMMERCIAL HMOs & THEIR POS PLANS IN MARYLAND

SEPTEMBER 2002

MARYLAND HEALTH CARE COMMISSION

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INTRODUCTION

I. INTRODUCTION

A. BACKGROUND

Of an estimated 3.7 million privately insured Maryland residents, 44 percent of them were reported as enrollees in Health Maintenance Organizations (HMOs) in 2000. Despite a dip in enrollment of almost two percentage points between 1999 and 2000, HMOs remain the most prevalent type of health care delivery system, both in the nation and state. HMOs, along with the providers in their networks, assume responsibility for the quality of the health care services received by their enrollees. This approach differs significantly from fee-for-service health care arrangements where individuals are responsible for seeking out health care providers and obtaining needed services. The HMO approach allows for measurement of care and services provided to a plan's enrolled population. The scrutiny that has resulted from that ability enables consumers and employers to judge the quality of care provided by HMOs and encourages HMOs to practice continuous quality improvement.

The purpose of the *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland* (*Comprehensive Report)* is to provide plans, providers, researchers, and other interested individuals with detailed, plan-specific, and Maryland-wide indicators of performance. This year's *Comprehensive Report* incorporates results from the 2002 Consumer Assessment of Health Plans Study (CAHPS®[1] 2.0H survey) and the Health Plan Employer Data and Information Set (HEDIS®[2]) data from reporting years 2000, 2001, and 2002. Indicators of clinical quality and member satisfaction, descriptive, and utilization information are drawn from CAHPS® and HEDIS results. The *Comprehensive Report* includes many HEDIS and CAHPS® measures that were not included in *The 2002 Consumer Guide to Maryland HMOs and POS Plans (Consumer Guide)*. A number of measures that are specific to Maryland can also be found in this report.

Because the performance of plans over time is more instructive than how they do in a single year, tables in the report illustrate both absolute changes in plans' rates as well as relative changes, i.e., how each plan compares to the average rates of all commercial Maryland health plans. In recognition of exceptional performance over time, plans are designated as "Star Performers" for eligible CAHPS® and HEDIS measures if the plan's rate was significantly higher than the Maryland HMO/POS average for each of the past three years, 2000, 2001, and 2002. Plans that performed better than the average rate of all commercial plans for a specific measure in 2002 are designated as above average in performance for one year.

Health plans, health benefit managers, employers, and state policy makers use quality information for a variety of purposes including:

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- determining areas for further study/investigation,
- targeting quality improvement initiatives,
- evaluating current initiatives,
- comparing to other plans, regions, the nation
- setting objectives, and
- making contracting decisions.

B. COMPANION REPORTS

For those interested in a simpler version of this report, *The 2002 Consumer Guide to Maryland HMOs and POS Plans (Consumer Guide),* provides a subset of measures selected for their interest to the general public.

The 2002 Guide to Maryland HMOs & POS Plans for State Employees contains information similar to the *Consumer Guide* but covers the three HMOs and two Point of Service (POS) products available to 70,000 employees of the State of Maryland in 2003.

In January of 2003, the Maryland Health Care Commission will release the sixth annual *Policy Report on Maryland Commercial HMOs & POS Plans* summarizing information across all plans and making comparisons to similar commercial plans in the region and nation.

An interactive version of the *2002 Consumer Guide* lets consumers create a customized report by selecting specific plans and comparing their performance on selected measures to the average rate of all commercial HMOs/POS plans in the State. All MHCC HMO/POS plan publications are available on the Internet at www.mhcc.state.md.us/hmoguide.

C. THE MARYLAND HEALTH CARE COMMISSION

The Maryland Health Care Commission (MHCC) is a public regulatory agency. Members of the MHCC are appointed by the Governor with the advice and consent of the Maryland Senate. Maryland law, Health General Article, Section 19-135C et seq., requires MHCC to establish and implement a system to comparatively evaluate the quality of care, outcomes, and performance of HMOs on an objective basis. The purposes of the system are to:

a) assist HMOs in improving quality of care by establishing a common set of performance measures; and
b) disseminate the findings of the performance measures to consumers, purchasers, HMOs, and interested parties.

The HMO quality and performance evaluation system developed by MHCC, and reflected in this report, is based on results from HEDIS developed by the National Committee for Quality Assurance (NCQA) and the CAHPS® 2.0H survey.

In addition to its mandates to assess the quality of commercial HMOs, MHCC also has the following responsibilities:

- Development of a comprehensive standard health benefit plan,
- Creation of a database of non-hospital health care services,
- Development of quality and performance measures for nursing homes, hospitals, and ambulatory surgical facilities and report findings.
- Implementation of a certificate of need program for certain health care facilities and services,
- Adoption of a state health plan related to certificate of need decisions, and
- Oversight of electronic claims clearinghouses.

MHCC, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, produced the online report *Maryland Nursing Home Performance Evaluation Guide*. The *Guide* provides comparative data that consumers can use to evaluate Maryland nursing homes. The *Hospital Performance Evaluation Guide* is the newest performance report released by MHCC. It features descriptive information on the 47 Maryland acute care hospitals. Both are accessible through the MHCC website at www.mhcc.state.md.us.

D. MARYLAND HEALTH PLANS

Maryland Health Plans in This Report

HMOs serving primarily the commercially insured population and receiving over one million dollars in Maryland premiums are required to report annually to MHCC on various measures of performance. Each plan has the option of reporting combined performance results for its HMO and POS products that operate under the license of its HMO. (POS members have access to the same provider networks and are covered under the same policies as HMO members. They can also choose to see providers outside the network in exchange for higher out of pocket costs.) Each plan, except Kaiser, has chosen to report on both HMO and POS performance. Although Kaiser does have a small POS plan, that plan's reported information is applicable to its HMO members only. **Throughout this publication, references to HMOs and HMO members should be understood to include members of POS plans for eight of the nine plans.** The table on the following page shows the plans for which data are included in this report along with their average monthly enrollment for 2001.

HMO/POS	% HMO Members	% POS Members	Total Members
Aetna US Healthcare, Inc.-Maryland, DC, Virginia **(Aetna)**	87	13	480,892
CareFirst BlueChoice, Inc. (formerly CapitalCare)**(BlueChoice)**	38	62	251,064
CIGNA HealthCare Mid-Atlantic, Inc. **(CIGNA)**	54	46	182,619
Coventry Health Care of Delaware, Inc. **(Coventry)**	88	12	100,904
Delmarva Health Plan **(Delmarva)**	99	1	18,668
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. **(Kaiser)**	97	3	479,886
MD-Individual Practice Association, Inc. **(M.D. IPA)**	72	28	158,145
Optimum Choice, Inc. **(OCI)**	82	18	457,771
Preferred Health Network **(PHN)**	37	63	67,698

Changes Among Commercial Plans

For the second year, the number of plans reporting to MHCC has declined. Consolidation of Aetna-owned plans into a single company led to the 2001 reduction. This year's edition reflects a departure from the market by George Washington University Health Plan and FreeState Health Plan. UnitedHealthcare of the Mid-Atlantic was granted an exemption from reporting because the majority of its HMO business is now Medicaid rather than commercial. Listed below is a brief overview of the plans included in this report.

- **Aetna** has consolidated Maryland operations into a single company.
- Four BlueCross BlueShield HMOs operate under a not-for-profit holding company called **CareFirst**. These CareFirst plans (all for-profit) are **Delmarva**, **BlueChoice, PHN,** and **FreeState**. Because **FreeState** is not renewing contracts and has stopped accepting new commercial groups, it was granted an exemption from submitting reports on its performance in 2002. Both Delmarva and FreeState have requested 2003 waivers from reporting on their performance. During fall 2001 open enrollment, the former **CapitalCare** was renamed **BlueChoice**. The proposed conversion of CareFirst to a for-profit company and sale to WellPoint Health Networks of California is under consideration by the Maryland Insurance Administration. The departments of insurance in Washington, D.C. and Delaware must also review the application for conversion and sale.
- Two HMOs, **M.D. IPA** and **OCI**, are owned and operated by Mid-Atlantic Medical Services, Inc. (MAMSI), a regional holding company.
- **Coventry** also is a regional company.

- **Aetna, CIGNA,** and **Kaiser** represent national health care insurers/providers in Maryland.
- Since **George Washington University Health Plan** ceased operations in March 2002, only one non-profit HMO, **Kaiser,** operates in Maryland.

As ownership of health plans in Maryland and throughout the country becomes concentrated in fewer but larger companies, real consumer choice becomes more limited.

E. REPORT ORGANIZATION

Organization of the *Comprehensive Report* is largely consistent with the domains and sequence of measures identified in the *HEDIS 2002, Volume 2: Technical Specifications* and commonly used by organizations reporting HEDIS information.

The report begins with a methodology section covering data sources, statistical methods, and general considerations for interpreting the data in the report.

After the methodology section, each section of the *Comprehensive Report* covers a HEDIS domain. A brief description of the domain opens each section. Results for measures within each domain then follow. For each measure, the following is provided:

- Background information describing the measure's importance and any relevant clinical or population health information,
- A definition of the measure consistent with *HEDIS 2002, Volume 2: Technical Specifications*,
- Notes describing any considerations regarding the generation or interpretation of results,
- A brief summary of plan rates/scores that identifies salient results, and
- Table(s) containing absolute rates (i.e., percentages, rates per 1,000 members), significant changes in absolute rates from 2000 to 2002, and relative rates (i.e., designation above/below Maryland HMO/POS average) for the past three years.

Plans are listed alphabetically in tables displaying their rates and the average rate for all Maryland plans for various measures derived from the 2002 CAHPS® 2.0H survey, HEDIS data set, and MHCC-specific measures of performance.

MHCC-specific measures have been included in sections on Behavioral Health Services and Use of Facilities. These descriptive and performance indicators were recommended by the Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations and MHCC. They are part of the set of mandatory performance measures that commercial HMOs in Maryland were required to report in 2002.

The final section of this report presents the accreditation status of each plan. NCQA and the American Accreditation Healthcare Commission (URAC) currently accredit commercial health plans and behavioral health plans in Maryland. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), which accredits United Healthcare in Maryland, now primarily a Medicaid plan, is also described. All are

independent organizations that accredit health plans through an external review process. In Maryland, accreditation is voluntary, i.e., not required by law. Information on which organizations accredit managed behavioral health organizations (MBHOs) is included in this section as well. Information on A.M. Best financial stability ratings is the final component of this section.

Appendix A, Health Plan Performance by Measure, sorts plan results by score rather than alphabetically for each measure, so the reader can see which plans performed best in each category of care. It also provides a listing by plan of all measures for which the plan achieved Star Performer status (performance that was above the average of all Maryland plans for each of the past three years). The number of above average scores the plan received in 2002 is also displayed.

Appendix B, Methods for Data Analysis, contains the methodology used in comparing plan performance and comparing rates across years for HEDIS and CAHPS® 2.0H survey measures.

Appendix C, Methodology for Audit of 2002 HEDIS Rates for Maryland HMOs & POS Plans, contains the 2002 audit methodology used in verifying that Maryland health plans followed the specifications created by NCQA when calculating the rates for each measure.

Appendix D, Methodology for Administering CAHPS® 2.0H Survey Results for Maryland HMOs & POS Plans, contains the survey methodology used in collecting and calculating the 2002 CAHPS® 2.0H survey results.

METHODOLOGY

II. METHODOLOGY

This section of the report provides underlying descriptive information about data sources used in the project. This is followed by a description of the statistical methods used to determine relative plan performance and the statistical significance of performance trends. The section continues with a discussion of the criteria used to identify Star Performers. It closes with a discussion of general considerations regarding interpretation of data contained in this report.

A. DATA SOURCES

Information in the *Comprehensive Report* is drawn primarily from two sources: HEDIS performance measures and CAHPS® 2.0H survey results. In addition, to satisfy legislative, task force and MHCC requirements, plans report on several measures of performance that are specific to this state. Those measures are referred to as MHCC-specific measures, because MHCC was charged with collecting and reporting data.

HEDIS Measures

HEDIS is a standard set of performance measures developed by the NCQA and experts representing many fields. NCQA is a not-for-profit organization that assesses, accredits, and reports on the quality of managed care organizations, including HMOs.

Rates for HEDIS 2002 measures in this report reflect services delivered during the 2001 calendar year. Similarly, 2001 and 2000 results presented in the report for trending purposes, reflect performance experiences from calendar years 2000 and 1999 respectively.

Based on the State of Maryland's information needs and expectations regarding reliability of data, MHCC required that plans report a total of 40 HEDIS measures for calendar year 2001. In addition, Maryland plans were asked to provide some specific data and information about their behavioral health services, pharmacy formulary development, and provision of after hours care.

This report presents results collected by the State of Maryland in seven general areas. The first six areas are consistent with HEDIS domains of care. The final category contains Maryland-specific data.

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care (CAHPS® 2.0H survey results)
- Health Plan Stability
- Use of Services
- Health Plan Descriptive Information
- MHCC-specific Measures of Performance

All measures required by MHCC in the Effectiveness of Care and Access/Availability of Care domains are included in this report. Measures included in the other domains were selected based upon public interest, results, independent audit findings, and aspects of health care represented by the measure. All aspects of health care measured by HEDIS (e.g., inpatient care, ambulatory care, maternity care, satisfaction, etc.) are represented by at least one measure.

All HEDIS measures collected by plans for MHCC have been audited according to the certified audit program established by NCQA. The NCQA HEDIS Compliance Audit™[3] is a standardized methodology that enables organizations to make direct comparisons of plans' rates for HEDIS performance measures. The audit is a two-part process consisting of an assessment of overall information systems capabilities followed by an evaluation of a plan's ability to comply with HEDIS specifications. HealthcareData.com, LLC, independently audited data displayed throughout this report under a separate, competitively bid contract with the MHCC. More information regarding the audit methodology can be found in Appendix C.

Data Collection Methodology

For many measures, HEDIS specifies a choice of administrative or hybrid data collection methodologies. The hybrid methodology allows health plans that do not adequately capture health care encounters to calculate rates that better reflect actual performance. For this project all of the selected *Effectiveness of Care* measures and *Well Child Visits* measures allow health plans to use either methodology.

Briefly, the two methodologies entail the following steps:

- ***Administrative methodology:*** After identifying the eligible member population for a measure, health plans search their administrative database (claims and encounter systems) for evidence of the service. Rates based on the administrative method are generally lower, but easier for health plans to produce than rates based on the hybrid data collection method.

- ***Hybrid methodology:*** The hybrid methodology allows health plans with incomplete administrative data to augment their HEDIS calculations with information gathered from medical records. Plans select a random sample of eligible members for a measure. The plan then searches its administrative databases for information about whether each individual in the sample received the service and then consults the medical records for evidence that the remaining individuals received the service.

[3] HEDIS Compliance Audit™ is a trademark of NCQA.

Rotation of Measures

NCQA allows health plans to rotate data collection for selected HEDIS measures. For measures that are rotated, data may be collected every other year, meaning that results for those selected measures are deemed valid for two years. The measures that NCQA selects for rotation are those that impose a substantial burden for health plans to collect, that have been part of the HEDIS measurement set for at least two years, and for which no significant changes have been made on how the data are collected and reported. If a health plan chooses to rotate a measure, valid results reported to MHCC in 2001 for the measure are also shown as 2002 results in this report. The table below indicates the measures eligible for rotation and which measures plans chose to rotate.

				Comprehensive Diabetes Care							
HMO/POS	Breast Cancer Screening	Cervical Cancer Screening	Controlling High Blood Pressure	Glucose Testing (HbA1c)	Glucose Control (HbA1c)	Eye Exam	Cholesterol Testing (LDL-C)	Cholesterol Control (LDL-C)	Monitoring Diabetic Nephropathy	Follow-up After Hospitalization for Mental Illness (7 & 30 days)	Prenatal and Postpartum Care
Aetna	Yes	Yes	Yes						Yes		Yes
BlueChoice	Yes	Yes		Yes	Yes	Yes			Yes		
CIGNA	Yes	Yes								Yes	
Coventry	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Delmarva		Yes			Yes						
Kaiser											
M.D. IPA			Yes								
OCI	Yes		Yes								
PHN											

Note: Due to the shortage of some immunizations, particularly for diphtheria, tetanus, and pertussis (DtaP) in 2001, NCQA allowed plans to treat the Childhood Immunization Status and Adolescent Immunization Status measures like rotated measures for HEDIS 2002 reporting. Those measures had also been rotated in 2001. However, Maryland health plans did not have this option. Maryland plans were required to collect and report new rates for childhood and adolescent immunization in 2002. Among Maryland plans, 2002 average rates were found to be the same for childhood immunization and improved for adolescent immunization, when compared to the previous year's rates, showing access to vaccine was not a problem in 2001.

Because a majority of Maryland plans chose to rotate two preventive care measures, screening for breast and cervical cancer, those two measures were not included in the set of measures for which plans could receive Star Performer designation in 2002. The decision to exclude them from the set arose when the majority of plans chose to present data collected in 2001, which do not reflect current performance. In 2003, MHCC will

consider whether plans in Maryland should continue to be permitted to rotate HEDIS measures for state reporting purposes.

In the results tables, plans that chose to rotate the measure are indicated by a superscript "r."

"Not Report" and "Not Available" Designations

According to NCQA guidelines, during the plan's HEDIS Compliance Audit, measures are assigned a "Not Report" designation if:

- The plan did not calculate the measure and a population existed for which the measure could have been calculated.
- The plan calculated the measure but chose not to report the rate.
- The plan calculated the measure but the rate was materially biased.

"Not Report" designations are denoted by "NR" in the tables in this report. Because plans **must** report a rate for each measure that is included in MHCC's requirements for annual performance, the first two categories of "Not Report" are not an option for Maryland plans. **Each NR designation that appears in Maryland HMO performance reports denotes failure to pass the audit for that specific measure. In some cases, measures for which rates appear may have failed the audit for a sub-component of the measure. For example, rates of immunization for a specific vaccine could have been designated as Not Report though the entire measure of childhood immunization could have been designated as reportable.**

When a plan can accurately generate a rate but its denominator (meaning the number of members who meet criteria for the measure in question) is less than 30, its rate will be reported as "Not Available" (NA). NCQA guidelines set 30 as the lower acceptable limit for denominators. When fewer than 30 people constitute the unit being compared, statistical validity, as well as meaningfulness of the measurement, is in question.

MHCC has found that NA ratings should not always be interpreted to mean that fewer than 30 members of an entire health plan met the criteria for a measure. Except in some instances, in very small plans, NA seems to denote a deficiency in the plan's data collection system, perhaps not identified during the audit, that does not allow it to accurately identify members who met criteria and may or may not have received the service being measured.

CAHPS® 2.0H Survey Measures

Consumers' experiences with their health care and health plans also are important measures of performance used to monitor quality. Collaboration between NCQA and the Agency for Healthcare Research and Quality (AHRQ) resulted in convergence of the former NCQA® Member Satisfaction Survey and the Consumer Assessment of Health Plans (CAHPS®) survey. The section of this report on satisfaction with the experience of care contains survey results from health plan members. The CAHPS® 2.0H survey

(included in HEDIS measurement set) has been administered to a different sample of Maryland commercial HMO members each year since 1999.

Various versions of the CAHPS® survey have been created: adult and child versions, as well as versions for commercial, Medicaid, and Medicare health plan members. All versions of the survey contain question sets covering such topics as enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics.

Since 1999, MHCC has contracted with Market Facts, Inc. to administer the CAHPS® 2.0H survey to the adult, commercial HMO population. Market Facts, Inc. is an NCQA-certified CAHPS® 2.0H survey vendor. A random sample of at least 950 members from each health plan was surveyed in 2002. The survey was administered according to the protocol outlined by NCQA. Additional information regarding the survey methodology, including recent changes to the protocol, can be found in Appendix D.

B. STATISTICAL ANALYSIS

Calculation of Relative Performance Rates

Performance categories, which rank a plan's performance on that measure as above average, average, or below average, were assigned by comparing each plan's rate to the unweighted average rate of all nine Maryland plans. Each plan contributed equally to the average rate, i.e., the average rate was determined by adding the rate for each plan and dividing by nine. If the difference between the plan's rate and the Maryland HMO/POS average was statistically significant, the plan was assigned to the above or below average category accordingly. To determine if the difference was statistically significant, the analysis uses a modified t-test that accounts for the error in measurement of the individual plan's rate as well as the error in measurement of the state HMO/POS average. A 95 percent degree of confidence was then used to determine if the difference between the rates was statistically significant. Appendix B provides a more detailed description of this methodology.

The tables in this report use the following symbols to denote relative comparisons:

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Note: The state averages for 2000 and 2001 include plans not shown in this report. They are based on the eligible plans in operation at that time and form the basis for the relative rates for those years.

Who Should Have Received the Service or Responded to the Question (Denominator Sizes) and Confidence Levels

The number of plan members who are considered eligible for a specific service are those who meet the qualifying criteria identified by each HEDIS measure, as described in NCQA's annual publication *HEDIS 2002, Volume 2: Technical Specifications*. Those members constitute the denominator of a rate. In statistical terms, the confidence interval around the rate is smaller. A larger denominator allows for a more precise estimate of the true rate.

Plans that use the administrative method to calculate a rate have smaller confidence intervals around their rates since the entire population eligible for the measure is used rather than a sample. *This means that two plans with the same percent result can be in two different performance strata.* For example, Plan A and Plan B both report a rate of 85 percent for a particular measure. The state HMO/POS average for this example is 80. Plan A used the hybrid method and its performance is designated as "average" when compared to the state average for all 9 plans due to its larger confidence interval. However, Plan B used the administrative method and its performance is designated as "above average" since its narrower confidence interval clearly exceeds the confidence interval around the state HMO/POS average.

Plans with the same rates also could be designated as performing at two different levels due to rounding. The statistical tests were conducted using entire numbers without rounding. Rates were then rounded for display in this report.

Calculation of Changes from 2000 to 2002

The trending tables contain a column titled "Change 2000-2002." The information in this column indicates whether a change in a plan's actual (absolute) rate from 2000 to 2002 is significant and, if so, the direction of the change. The table uses the following symbols:

↑ = Plan's rate increased significantly from 2000 to 2002
⇔ = Plan's rate did not change significantly from 2000 to 2002
↓ = Plan's rate decreased significantly from 2000 to 2002

This indicator shows whether a plan's absolute or actual rate has improved over time. Note that this calculation is independent of the plan's relative rate. For example, a plan's rate may have changed from 65% in 2000 to 75% in 2002, a significant increase that would be identified with the "↑"symbol. However, if the Maryland HMO/POS average changed, for example, from 60% in 2000 to 80% in 2002, the plan's relative rate may have been above average in 2000, but below average in 2002 (i.e., even though its absolute rate increased significantly, it increased less significantly than the Maryland HMO/POS average over the same period).

The "Change 2000-2002" column indicates changes in the plan's own performance as measured by change in its absolute rate. **It is not an indicator of the consistency of a plan's performance (above, average, or below) in relation to other plans.**

The three columns labeled "Comparison of Relative Rates" show how each plan performed in relation to the other plans that reported each year. The relative rate trend is an indicator of the consistency of a plan's performance (above, average, or below) in relation to other plans as reflected by the Maryland HMO/POS average.

Note that the term "significance" is used in the statistical sense. For example, a significant change in a plan's rate from 2000 to 2002 means that the change is very unlikely to occur due to chance variation. It does not describe, however, the magnitude of that change. A one-percent change can be considered significant if the population on which it is based is large, as is often the case with HEDIS rates calculated using the administrative method.

C. STAR PERFORMERS

To be considered a Star Performer for a specific measure, a health plan must maintain an above average level of performance for each of the past three years, as identified by the statistical significance test described in the previous section. Only measures reported in the *Consumer Guide* are considered when conferring Star Performer status upon plans.

To be eligible to receive this designation, plans must have existed in their current form, doing business in Maryland for the past three years. Aetna US Healthcare, Inc.-Maryland, DC, Virginia, reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation in 2002. BlueChoice is eligible because only the name of the plan changed in 2002. The 2000 and 2001 performance of CapitalCare is attributed to BlueChoice.

Measures were not included in the evaluation of Star Performers if the measure, or the manner in which MHCC has reported plan performance of the measure, has changed materially within the past three years. In total, seven CAHPS® 2.0H measures and twelve HEDIS measures were eligible for Star Performer status in 2002. The eligible measures follow:

HEDIS

- Childhood Immunization Status (Combination 2)
- Controlling High Blood Pressure
- Beta Blocker Treatment After a Heart Attack
- Cholesterol Management After Acute Cardiovascular Events, Cholesterol (LDL-C) Testing
- Comprehensive Diabetes Care, Blood Glucose (Hemoglobin A1c, HbA1c) Testing
- Comprehensive Diabetes Care, Cholesterol (LDL-C) Testing
- Comprehensive Diabetes Care, Eye Exam Performed
- Use of Appropriate Medications for People with Asthma (combined rate of age 5-56 years)
- Follow-Up After Hospitalization for Mental Illness, 30 Day Follow-Up measure
- Prenatal and Postpartum Care, Postpartum measure

- Well-Child Visits for Infants and Children (combined rate of age 15 months and 3-6 years)
- Adolescent Well-Care Visits

CAHPS®2.0H

- How Members Rate Their Health Plan
- Few Consumer Complaints
- Health Plan Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Often Doctors Communicated Well
- Rating of Health Care Received

Star Performer information appears in the following places in this report:

- In trending tables, asterisks appear next to the plan name if the plan has been designated as a Star Performer for the measure.
- Table 87 ("Star Performers by Plan") in Appendix A – Health Plan Performance by Measure provides a listing by plan of the measures for which it has attained Star Performer status.

D. GENERAL CONSIDERATIONS FOR INTERPRETATION OF INFORMATION IN THIS REPORT

Data Loss and Completeness

The health care marketplace is changing rapidly. Health plans continually merge or acquire other plans. Whether due to a merger or an acquisition, the surviving health plan must integrate all data from predecessor plans to report the health care experiences of all members. Administrative data systems conversions can be complex and can lead to loss of data. Even if a systems conversion has not taken place, creating HEDIS measures from multiple systems can raise data integration issues that may lead to data loss. Quantifying data loss is extremely difficult.

Data completeness is another issue that many health plans face. The plan may not have complete data on all of the services rendered to its members for many reasons. For some HMO providers, payment is capitated and is not associated with each individual service rendered to enrollees. Therefore, providers may not always submit the information to the HMO even though care was provided. Similarly, many HMOs do not receive complete data from contractual vendors who provide services such as laboratory, radiology, pharmacy, and mental health. In some instances, plans do not have data for some members because the member's employer contracted with a different company to provide certain services, such mental health. Behavioral health care and pharmacy coverage are often provided by a different company than the company that provided health services. When health plans contract with another company or provider to deliver services, the

health plan remains responsible for the care provided by their contractors and for data associated with provision of care.

Medical coding is another factor that may affect completeness of a plan's data. HEDIS measures rely on standard coding (i.e., ICD-9, CPT-4, etc.) to capture information on the delivery of services from their administrative data. The minimum level of specificity required for a service to be counted in the HEDIS rate is indicated in the *HEDIS 2002, Volume 2: Technical Specifications*. Plans, however, are dependent on their providers to use the correct code for the service that was rendered. Some plans create their own codes to represent certain services for billing purposes. In many cases, these so-called "home-grown codes" cannot be used to calculate the HEDIS rate in accordance with NCQA specifications. As the Health Insurance Portability and Accountability Act is phased in, use of home grown codes by health plans will be phased out.

All of these factors can cause variation in HEDIS results that are not attributed to differences in performance. Although plans continually work to improve their data for use in performance measurement and quality improvement, demonstrating the effects of these efforts on final HEDIS rates is extremely difficult.

Administrative vs. Hybrid Data Results

In recognition of the industry-wide problem of data incompleteness, many HEDIS measures can be calculated by supplementing administrative data from the plan with information from the enrollee's medical record. This is called the hybrid methodology.

Because they count service information from the medical record (not just administrative data systems), plans that use the hybrid method tend to report higher rates that those that use administrative systems alone. However, medical record reviews are both time and cost-intensive, and many plans simply do not have the resources to conduct complete medical record reviews. As a result, the plan may not capture all relevant services for reporting its HEDIS rates.

In the trending tables for hybrid-eligible measures, plans that use only administrative data to generate their rate are indicated by a superscript "m."

Performance Measurement Issues

Methods for assessing health plan performance are continually under development. Each year, HEDIS measures are refined and new measures are added to create a more accurate means of evaluating health plan performance. Despite having a standardized set of measures, some factors may still influence a plan's results. Throughout this report, factors to consider when interpreting the results will be presented when applicable. In addition to differences in quality, the following issues can cause variation in HEDIS results.

- Many HEDIS measures are calculated from samples of the plan population. Although sampling methods plans used conform to statistical methods, there is still a small chance that the sample does not represent the underlying population. Although the likelihood of this random error occurring is small, the estimate

obtained with a sample may produce a result that exceeds the error tolerance of 5% set by NCQA specifications.

- HEDIS results are not risk-adjusted. There may be differences in the plans' populations that cause variation of the rates even when the quality of the health care delivered is the same. For example, Plan A may have a sicker population than Plan B. Although both plans may provide the same quality of care, Plan A may have higher utilization rates for some services because their enrollees need more medical care than do the healthier members of Plan B. Therefore, variation in rates for some HEDIS measures such as Use of Services and Frequency of Selected Procedures results would not be due to differences in performance.

  Studies supported by the Agency for Healthcare Research and Quality have shown differences in HEDIS rates due to education and economic differences in plan members. Better-educated members tend to demand and get better services.

- Finally, HEDIS results are only as accurate as the data used to produce the measures. Several factors can affect availability and completeness of data used to produce the HEDIS measures. The common practice of contracting out specific services, like behavioral health services, pharmacy, laboratory, and radiology present challenges to accountability in data collection and reporting for some plans. **Plans remain legally responsible for services even when they pay to have someone else deliver the service.** This problem becomes even more complex when employers "carve out" some types of services from their contract with a health plan. In those instances, the plan is not responsible for the delivery of the specified services or data collection or reporting.

Healthy People 2010 Objectives

For some Effectiveness of Care measures, this report includes comparisons to *Healthy People 2010*. The 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* established national health objectives and served as the basis for the development of state and community plans. *Healthy People 2010* builds on initiatives pursued over the past two decades by the United States Public Health Service for improving health among Americans. Where similar measures exist, Healthy *People 2010* objectives have been cited.

Readers are cautioned that important differences exist between HEDIS measures and the objectives in *Healthy People 2010.* Of primary importance is that the populations each considers are different. To explain, HEDIS measures are designed and used for an insured population with access to care whereas *Healthy People 2010* objectives are public health objectives for the entire population, of which a significant proportion does not have health insurance. HEDIS and *Healthy People 2010* also use different definitions and specifications for performance measures.

An example of measurement differences occurs with childhood immunizations. The objective for *Healthy People 2010* is to identify the proportion of the population who received "basic immunizations" through two years of age. In contrast, the HEDIS measure looks at the percent of children who have received specified vaccines by their second birthday. Despite these differences, the report includes some references to the *Healthy People 2010* objectives because they are widely recognized external comparisons.

Impact of Consolidation of Aetna Plans

As indicated in the Introduction section, in the 2001 reporting year, Aetna U.S. Healthcare, Inc. consolidated operations in Maryland into a single company called Aetna U.S. Healthcare, Inc. - Maryland, DC, Virginia. In 2000, Aetna operated four plans in Maryland, and therefore performance results for each of those plans were reported separately in the 2000 MHCC HMO reports. The four plans did business as:

- Aetna US - MD
- Aetna US - VA
- Aetna/NYLCare
- Prudential/Aetna

Consolidation of the Aetna plans continues to impact a comparison of the Maryland HMO average between 2002 and prior years. The Maryland HMO average is calculated as a simple average of the rates of all commercial plans operating in Maryland during the reporting year. The average is not weighted by plan enrollment.

In 2000, a total of 15 HMOs were included in the calculation of the Maryland HMO average, four of which were operated by Aetna. In 2001, a total of 12 HMOs were included in the calculation of the Maryland HMO average only one of which was operated by Aetna.

In 2002, nine plans were included in the average and, again, only one plan was operated by Aetna.

If the rates for Aetna plans, as a group, are significantly different from the average of other plans, the consolidation of the Aetna plans would cause a shift in the Maryland HMO average.

This shift, which was seen in 2001 and 2002, is not a result of changes in HMO performance across Maryland. It results because the method used to calculate the Maryland average is sensitive to changes in the number of plans when plans that perform better or worse than average combine or leave the market.

Consolidation of Aetna plans contributed significantly to a change in the Maryland average for the following measures from 2000 to 2002. The measures were:

- Children's Access to Primary Care Providers, 25 Months-6 Years
- Children's Access to Primary Care Providers, 7-11 Years

- Chlamydia Screening, Age 16-20
- Chlamydia Screening, Age 21-26
- Board Certification, Pediatrician and Other
- Well-Child Visits in the First Fifteen Months
- Well-Child Visits in the 3rd, 4th, 5th, 6th Years
- Well Child Composite
- Adolescent Well-Care

For these measures, readers are cautioned not to interpret changes in the Maryland HMO/POS average for the three years displayed here as resulting only from changes in plan performance. Note that the Maryland HMO average is dynamic and the plans that contribute to it change each year. Relative ranks reported for 2000 and 2001 are based on the plans in existence during 1999 and 2000, just as the Maryland average for 2002 is composed of plans and their data from calendar year 2001.

EFFECTIVENESS OF CARE MEASURES

III. EFFECTIVENESS OF CARE MEASURES

Summary

This section contains results for the HEDIS Effectiveness of Care measures that MHCC required Maryland commercial HMOs to report in 2002. These measures, listed in the table below, are designed to illustrate the plan's delivery of clinical services in accordance with established and widely accepted guidelines. Effectiveness of Care measures reveal what percent of people who should have received a service actually did receive the service. Unless otherwise noted, for all of the measures presented in this section, higher rates indicate better performance.

Measure	Description
Childhood Immunization Status	The percent of children who received specified immunizations by age 2.
Adolescent Immunization Status	The percent of adolescents who received specified immunizations by age 13.
Breast Cancer Screening	The percent of women age 52-69 who had a mammogram within the past two years.
Cervical Cancer Screening	The percent of women age 21-64 who received a pap smear test within the past three years.
Chlamydia Screening in Women	The percent of sexually active women age 16-26 who had at least one chlamydia test during the measurement year.
Controlling High Blood Pressure	The percent of members age 46-85 with a diagnosis of hypertension who had their blood pressure under control.
Beta Blocker Treatment After a Heart Attack	The percent of members age 35 and older that were hospitalized, diagnosed with acute myocardial infarction, discharged alive, and dispensed a prescription for beta blockers upon discharge.
Cholesterol Management After Acute Cardiovascular Events	The percent of members age 18-75 that were discharged alive in the year prior to the measurement year for AMI, coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), and had a cholesterol (LDL-C) screening and cholesterol (LDL-C) level <130mg/dL between 2-12 months of discharge from a hospital.
Comprehensive Diabetes Care	The percent of members with diabetes age 18-75 who had each of the following: glucose (HbA1c) tested, glucose (HbA1c) controlled, cholesterol (LDL-C) tested, cholesterol (LDL-C) controlled, dilated eye exam, kidney disease monitored.
Use of Appropriate Medications for People with Asthma	The percent of members age 5-56 with persistent asthma who were prescribed inhaled corticosteriods (or one of three alternative medications) as primary therapy for long-term control of asthma.
Follow-up After Hospitalization for Mental Illness 7 day and 30 day	The percent of members age 6 or older that were hospitalized for mental health disorders that were seen on an ambulatory basis within 7 and 30 days of discharge.

Measure	Description
Antidepressant Medication Management	The percent of members age 18 or older who had pharmacological management of depression, as denoted by 3 separate components: 1) optimal contact with practitioner for medication management during 3-month acute phase, 2) effective acute phase treatment (3 months), 3) effective continuation phase treatment (6 months).
Flu Shots for Adults 50-64	The percent of members age 50-64 who received an influenza vaccination.
Advising Smokers to Quit	The percent of adult smokers who received advice to quit smoking from a health professional in the plan. (Not reported until 2003.)

The HEDIS 2002 rates in this report reflect services delivered during the 2001 calendar year. Similarly, 2001 and 2000 results presented in the report for trending purposes reflect performance and experiences from 2000 and 1999 calendar years, respectively.

Rotation of Measures

Because all but one of the measures that are eligible for rotation are Effectiveness of Care Measures, the following information, also displayed in the Methodology Section is presented here.

NCQA allows health plans to rotate data collection for selected HEDIS measures. For measures that are rotated, data may be collected every other year, meaning that results for those selected measures are deemed valid for two years. The measures that NCQA selects for rotation are those that impose a substantial burden for health plans to collect, that have been part of the HEDIS measurement set for at least two years, and for which no significant changes have been made on how the data are collected and reported. If a health plan chooses to rotate a measure, valid results reported to MHCC in 2001 for the measure are also shown as 2002 results in this report. The table below indicates the measures eligible for rotation and which measures plans chose to rotate.

				Comprehensive Diabetes Care							
HMO/POS	Breast Cancer Screening	Cervical Cancer Screening	Controlling High Blood Pressure	Glucose Testing (HbA1c)	Glucose Control (HbA1c)	Eye Exam	Cholesterol Testing (LDL-C)	Cholesterol Control (LDL-C)	Monitoring Diabetic Nephropathy	Follow-up After Hospitalization for Mental Illness (7 & 30 days)	Prenatal and Postpartum Care
Aetna	Yes	Yes	Yes						Yes		Yes
BlueChoice	Yes	Yes		Yes	Yes	Yes			Yes		
CIGNA	Yes	Yes								Yes	
Coventry	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Delmarva		Yes			Yes						
Kaiser											
M.D. IPA			Yes								
OCI	Yes		Yes								
PHN											

In the results tables, plans that chose to rotate the measure are indicated by a superscript "r."

Because a majority of Maryland plans chose to rotate two preventive care measures, breast cancer screening and cervical cancer screening, those two measures were not included in the set of measures for which plans could receive Star Performer designation in 2002. The decision to exclude them from the set arose when the majority of plans chose to present data collected in 2001, which do not reflect current performance. In 2003, MHCC will consider whether plans in Maryland should continue to be permitted to rotate HEDIS measures for state reporting purposes.

Changes to HEDIS for 2002

Flu Shots for Adults Ages 50-64

Flu Shots for Adults Ages 50-64 is a new measure that looks at the percentage of members age 50-64 who received an influenza vaccination during the previous flu season. Developed in collaboration with the CDC, this measure is based on a response item in the CAHPS® 2.0H Adult Commercial Survey. The specifications for this measure are consistent with current recommendations from the Advisory Committee on Immunization Practices.

The burden of influenza-related morbidity and mortality among people 50-64 is significant. Hospitalization rates for people in this age group have varied between 80 and 400 per 100,000 for those with high-risk conditions and from approximately 20 to 40 per 100,000 for those without such conditions. Of the 20,000 influenza-associated deaths per year, about nine percent occur among people ages 50-64. The disease burden for influenza is large and the potential for prevention is high. Influenza infections result in significant health care expenditures each year and vaccination is safe and effective.

Advising Smokers to Quit

The Advising Smokers to Quit measure determines the percentage of adult (age 18 or older) current smokers or recent quitters, who were seen by a plan practitioner during the measurement year and received advice to quit smoking from the practitioner. This measure is calculated using patient survey data collected as part of the CAHPS® 2.0H Adult survey.

In 2002, NCQA revised the reporting strategy for this measure. It is no longer part of the rotation strategy used in prior years. Rather than increasing the sample size for alternating years, plans will administer the survey for two consecutive years to achieve a denominator sufficient to calculate the results. Thereafter, a moving average will be calculated based upon data gathered during the reporting year and the year prior. This means that results will not be publicly reported until 2003, therefore it is not included in this report.

A. CHILDHOOD IMMUNIZATION STATUS

Background

Childhood immunizations protect children from serious illnesses such as polio, tetanus, measles, and chicken pox. Vaccines are one of medicine's best examples of primary prevention and are an easy, proven way to help children stay healthy and avoid potentially harmful effects of childhood diseases such as mumps and measles. Prevention of these diseases, even when illnesses are mild, saves hundreds of school and workdays that would be lost.

Although the incidence of preventable childhood diseases has declined due to high rates of vaccination in school-age children, many children do not receive sufficient immunization to meet recommended guidelines. The following is a schedule of immunizations recommended as of December 2001 by the U.S. Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians:

Age	DTaP/ DT	IPV	MMR	Hep B	HiB	VZV	PCV
Birth-2 mos.				✓			
1-4 mos.				✓			
2 mos.	✓	✓			✓		✓
4 mos.	✓	✓			✓		✓
6 mos.	✓				✓		✓
6-18 mos.		✓		✓			
12-15 mos.			✓		✓		✓
12-18 mos.						✓	
15-18 mos.	✓						

Source: American Academy of Family Physicians, Recommended Childhood Immunization Schedule – United States, January – December 2002

Web page: http://www.aafp.org/x7666.xml

The vaccines, abbreviated as noted, protect against the following diseases:

DTaP/DT – diphtheria, tetanus, and pertussis
IPV – polio
MMR – measles, mumps, and rubella
Hep B – hepatitis B
HiB – haemophilus influenza type b
VZV – chicken pox
PCV – pneumonia

Definition of Measure

The Childhood Immunization rate shows what percent of children who turned two years old during 2001, and were continuously enrolled in their health plan for 12 months immediately preceding their second birthday have received immunizations as specified for the two HEDIS-defined combinations listed below.

Combination 1	*Combination 2*
4 DtaP/DT	4 DtaP/DT
3 IPV/ OPV	3 IPV/ OPV
1 MMR	1 MMR
3 Hep B	3 Hep B
3 HiB	3 HiB
	1 VZV

This report also contains 2002 rate results for the specific antigens that comprise each combination vaccine. While rates for Combination 1 have been reported for a number of years, this combination no longer constitutes adequate immunization. It is not reported in the *Consumer Guide.*

Notes

Combination 2 is largely compliant with broad guidelines set by the U.S. Centers for Disease Control. Several exceptions are noteworthy. The CDC recommends IPV antigen to prevent polio, but HEDIS specifications allow for administration of either IPV or OPV. In addition, pneumococcal conjugate vaccine (PCV) is included in the CDC 2002 Recommended Immunization Schedule. Four PCV vaccinations are recommended for all children 2 to 23 months of age. This recommendation was not incorporated into the HEDIS specifications.

In 2002, NCQA incorporated into HEDIS a recommendation of the CDC's Advisory Council on Immunization Practices and required a minimum of three HiB vaccines (instead of two) prior to a child's second birthday. Beginning in 2003, HEDIS guidelines will not count as "compliant" any DTaP/DTP, IPV/OPV or HiB vaccinations given to a child younger than six weeks.

Vaccine shortages and shipment delays that arose during 2001 had a varied impact upon different regions of the country. NCQA allowed plans to treat the childhood immunization measure like rotated measures for HEDIS 2002 reporting. This measure had also been rotated in 2001. However, Maryland plans were required to report both child and adolescent immunization rates and were not permitted to rotate these measures in 2002.

In 2001, the measurement year for which rates are displayed here, Maryland was not affected until late in the year and with only limited problems. The 2002 average rates were compared to the previous year and were found to be the same for childhood

immunization status and improved for adolescent immunization status, showing access of vaccine was not a significant problem for Maryland in 2001.

Several factors complicate calculating this measure and can lead to under-reporting. When interpreting results, readers should consider the following:

- Children who receive some, or even most, but not all of the immunizations specified for the combination are excluded from the numerator of the rate. Vaccine-specific or single antigen rates are almost always higher than the rates for combinations but, of course, they alone do not constitute adequate immunization.
- All plans have difficulties documenting immunizations that were received outside of their network (e.g., at schools, local health departments, etc.). *Maryland is in the process of developing the Maryland Immunization Registry to centralize this information to provide complete and accurate records through a confidential and secure computer system.*
- Disease history or evidence of a seropositive test is considered equivalent to being immunized against the disease in question.
- Children who previously had chicken pox do not receive the VZV vaccine. However, history of chicken pox often is not documented in a child's medical record since medical treatment is not always necessary. Therefore, children with a history of chicken pox are not always included in the numerator of the measure as specified.
- Poor quality of coding for ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. Providers often do not include antigen-specific codes for immunizations on encounter forms submitted to plans.
- Many children receive recommended immunizations shortly *after* their second birthday. Although the intent of the measure is satisfied, these children must be excluded (as indicated in the *HEDIS 2002, Volume 2: Technical Specifications*, which guide calculating rates for HEDIS measures to ensure the comparability of results across plans).

Results

Antigen-Specific Vaccination Rates

This report shows the rates for antigen-specific vaccinations in Table 3.

Combination 1

From 2000 to 2002, four of the eight plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased five percentage points over this period to 71% (see Table 1).

In 2002, **rates ranged from 50% to 82%** with four plans receiving average scores, three plans were above average, and two plans were below average. This combination is displayed for the purpose of showing trends over time, but is no longer where plans should focus their attention. Combination 2 is the current marker for performance.

Combination 2

From 2000 to 2002, five of the eight plans reporting for all three years improved their rates significantly (see Table 2). The Maryland HMO/POS average increased nine percentage points over this period. More plans increased their rates for Combination 2 than were able to increase their rates for Combination 1. This indicates that plans have reported a greater increase in the rate of VZV immunization.

In 2002, the average rate for all plans was 66%. **Rates ranged from 48% to 79%** with two plans receiving average scores, five plans were above average, and two plans were below average. Two plans are Star Performers (see Table 3).

Table 1

Combination 1 does not include the vaccine for chicken pox (VZV)

Childhood Immunization Status Combination 1, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**66%**	**73%**	**71%**	**5%**			
Aetna	--	73%	74%	--	--	⊙	⊙
BlueChoice	60%	73%	69%	↑	○	⊙	⊙
CIGNA	65%	76%	75%	↑	⊙	⊙	⊙
Coventry	75%	75%	81%	↑	●	⊙	●
Delmarva	63%	63%	50%	↓	⊙	○	○
Kaiser[m]	89%	89%	82%	↓	●	●	●
M.D. IPA	73%	78%	76%	⇔	●	●	●
OCI	62%	71%	75%	↑	⊙	⊙	⊙
PHN	59%	59%	59%	⇔	○	○	○

Legend:

Change 2000-2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

Table 2

Combination 2 does include the vaccine for chicken pox (VZV)

Childhood Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**57%**	**66%**	**66%**	**9%**			
Aetna	--	67%	69%	--	--	⊙	⊙
BlueChoice	50%	67%	65%	↑	○	⊙	⊙
CIGNA	56%	72%	70%	↑	⊙	●	●
Coventry	57%	57%	70%	↑	⊙	○	●
Delmarva	59%	59%	49%	⇔	⊙	○	○
*Kaiser[m]	82%	82%	79%	⇔	●	●	●
*M.D. IPA	63%	72%	72%	↑	●	●	●
OCI	50%	63%	71%	↑	○	⊙	●
PHN	48%	48%	48%	⇔	○	○	○

Legend:

Change 2000-2002

↑ Plan's rate increased significantly from 2000 to 2002

⇔ Plan's rate did not change significantly from 2000 to 2002

↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average

⊙ = Plan performed equivalent to the Maryland HMO/POS average

○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2001" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 3

Childhood Immunization Status, 2002 Results																
	Percent of Children Immunized															
	Combination 1		Combination 2		DTP		OPV		MMR		HiB		Hep B		VZV	
Maryland HMO/POS Average	71%		66%		85%		90%		92%		87%		82%		86%	
Aetna	74%	⊙	69%	⊙	85%	⊙	89%	⊙	91%	⊙	88%	⊙	85%	●	87%	⊙
BlueChoice	69%	⊙	65%	⊙	81%	○	84%	○	90%	⊙	82%	○	80%	⊙	82%	⊙
CIGNA	75%	⊙	70%	●	83%	⊙	87%	⊙	93%	⊙	87%	⊙	87%	●	89%	⊙
Coventry	81%	●	70%	●	89%	●	93%	●	95%	●	92%	●	90%	●	83%	⊙
Delmarva	50%	○	49%	○	90%	⊙	93%	⊙	94%	⊙	78%	○	65%	○	93%	●
Kaiser[m]	82%	●	79%	●	87%	●	90%	⊙	91%	⊙	91%	●	88%	●	87%	●
M.D. IPA	76%	●	72%	●	88%	⊙	93%	●	93%	⊙	90%	●	85%	●	88%	⊙
OCI	75%	⊙	71%	●	85%	⊙	90%	⊙	93%	⊙	89%	⊙	84%	⊙	89%	●
PHN	59%	○	48%	○	80%	○	90%	⊙	84%	○	83%	○	72%	○	74%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- Combination 1 does not include the chicken pox vaccine (VZV). This combination no longer constitutes adequate immunization.
- Combination 2 does include the chicken pox vaccine (VZV).

B. ADOLESCENT IMMUNIZATION STATUS

Background

Immunizations are just as important to adolescents as they are to children. Although much of the focus for intervention has been on infants and children, health plans should encourage recommended immunizations according to the official schedule for adolescents. The CDC, the AAP, and other experts recommend that, depending on the vaccinations received previously, by the time children are 13 years old they should have received a second dose of measles-mumps-rubella (MMR), four hepatitis B (Hep B) vaccines, a tetanus booster, and a chicken pox (VZV) vaccine. If they have already had the disease they should not receive the vaccination. Additionally, a fourth polio vaccine at age 4-6 is recommended.

Recommended Adolescent Immunizations

Age	DtaP/ DTP	IPV	MMR	Hep B	VZV	Td	Hep A*
2 yrs. +							✓
4-6 yrs.	✓	✓	✓				
11-12 yrs.				✓	✓		
11-16 yrs.						✓	

The vaccines listed protect against certain diseases:

DTaP/TD – diphtheria, tetanus, and pertussis
IPV – polio virus
MMR – measles, mumps, and rubella
Hep B – hepatitis B
VZV – chicken pox
Td – tetanus and diphtheria
Hep A* – hepatitis A

*** DHMH, Center for Immunization Recommended Childhood Immunization Schedule - 2002** includes 2 doses of hepatitis A vaccine for Baltimore City residents

Definition of Measure

This measure shows what percent of adolescents who turned 13 during the measurement year (2001), and were continuously enrolled for 12 months immediately preceding their 13th birthday, received the following immunizations as specified for each of the NCQA-recognized combinations. As is the case with immunization for children, the distinction between Adolescent Immunization Combination 1 and 2 is that Combination 2 includes the vaccine for chicken pox (VZV). This is the combination that is recommended by experts.

Combination 1
Second dose of MMR
3 Hep B (or two dose regimen)

Combination 2
Second dose of MMR
3 Hep B (or two dose regimen)
1 VZV

While rates for Combination 1 have been reported for a number of years, this combination no longer constitutes adequate immunization.

This year, the *Comprehensive Report* also contains 2002 rate results for the antigen-specific vaccines that comprise each combination.

Notes

Beginning in reporting year 2001, the HEDIS Technical Specifications changed to allow health plans to count members as compliant toward the hepatitis B indicator if they received the two-dose regimen identified with CPT code 90743.

Combination 1, without the vaccine for chicken pox or the tetanus booster, is less comprehensive than what is recommended by experts in preventive and clinical care. See the chart above for current (2002) recommended vaccines, per CDC, AAP, and the Maryland Center for Immunization. Combination 2 does include the chicken pox vaccine (VZV).

Several factors complicate calculating this measure and can lead to under-reporting. When interpreting results, readers should consider the following:

- Adolescents who receive some, but not all, of the immunizations specified for the combination are excluded from the numerator of the rate. Vaccine-specific or antigen-specific rates are always higher than the combination rates, but individual vaccines alone do not provide sufficient protection
- All plans have difficulties documenting immunizations that were received outside of the network (e.g., at schools, local health departments, etc.)
- Disease history or evidence of a seropositive test is considered equivalent to being immunized against the disease.
- Adolescents who previously had chicken pox do not receive the VZV vaccine. However, history of chicken pox often is not documented in an adolescent's medical record since medical treatment is not always necessary. Adolescents with a history of chicken pox are not always included in the numerator of the measure as specified. This is especially problematic for this measure since adolescents could have had chicken pox at any time up to their thirteenth birthday, and most adolescents have not been in the same plan for that entire time.
- Poor quality in coding of ambulatory data is commonly found in capitated managed care environments and can complicate accurate measurement. Providers often do not include antigen-specific codes for immunizations on encounter forms submitted to plans.

Results

This measure is not eligible for the Star Performer designation; Combination 2 was reported for first time in the *Consumer Guide* in 2002. Neither Combination 2 nor the formerly reported Combination 1 measure is eligible for the Star Performer designation.

Antigen-Specific Vaccination Rates

Table 6 shows the rates for antigen-specific vaccinations. Consistent with rates for the Childhood Immunization measure, VZV and hepatitis B vaccination rates were significantly lower than those for MMR.

Combination 1

From 2000 to 2002, five of the seven plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased 16 percentage points over this period (see Table 4).

In 2002, two plans received average scores, three plans were above average, and four plans were below average. Rates ranged widely from 24% to 75%.

Combination 2

From 2000 to 2002, six of the eight plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased 13 percentage points over this period. In 2002, five plans received average scores, two plans were above average, and two plans were below average. Rates ranged from 15% to 38%. Work needs to be done to improve performance in this area. The percent of adolescents who receive adequate immunization is 27% across all plans. Even considering the old Combination 1, without vaccine for chicken pox, only 44% percent of adolescents had been immunized in 2002 (see Table 5).

As with the Childhood Immunization measure, more plans increased their rates for Combination 2 than were able to increase their rates for Combination 1. This indicates that plans have reported a greater increase in the rate of VZV immunization.

Table 4

Combination 1 does not include the chicken pox vaccine (VZV)

Adolescent Immunization Status Combination 1, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**28%**	**39%**	**44%**	**16%**			
Aetna	--	36%	38%	--	--	⊙	○
BlueChoice	23%	39%	43%	↑	○	⊙	⊙
CIGNA	23%	29%	39%	↑	○	○	○
Coventry	NR	64%	75%	NR	NR	●	●
Delmarva	29%	40%	51%	↑	⊙	⊙	●
Kaiser[m]	54%	54%	51%	⇔	●	●	●
M.D. IPA	28%	38%	43%	↑	⊙	⊙	⊙
OCI	26%	34%	35%	↑	⊙	○	○
PHN	27%	27%	24%	⇔	⊙	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NR = Not Reportable. Data did not pass independent audit.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- In 2002, it is not possible for any plan to be a Star Performer for either Adolescent Immunization measure.

Table 5

Adolescent Immunization Status Combination 2, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**14%**	**23%**	**27%**	**13%**			
Aetna	--	20%	24%		--	⊙	⊙
BlueChoice	13%	21%	28%	↑	⊙	⊙	⊙
CIGNA	8%	17%	25%	↑	○	○	⊙
Coventry	NR	25%	38%	NR	NR	⊙	●
Delmarva	14%	22%	28%	↑	⊙	⊙	⊙
Kaiser[m]	50%	50%	35%	↓	●	●	●
M.D. IPA	11%	25%	28%	↑	○	⊙	⊙
OCI	10%	22%	22%	↑	○	⊙	○
PHN	8%	8%	15%	↑	○	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- NR = Not Reportable. Data did not pass independent audit.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- In 2002, it is not possible for any plan to be a Star Performer for either Adolescent Immunization measure.

Table 6

Adolescent Immunization Status, 2002 Results										
Percent of Adolescents Immunized										
	Combination 1		Combination 2		MMR		Hep B		VZV	
Maryland HMO/POS Average	**44%**		**27%**		**73%**		**48%**		**41%**	
Aetna	38%	○	24%	⊙	69%	○	41%	○	38%	⊙
BlueChoice	43%	⊙	28%	⊙	71%	⊙	46%	⊙	43%	⊙
CIGNA	39%	○	25%	⊙	70%	⊙	41%	○	43%	⊙
Coventry	75%	●	38%	●	87%	●	78%	●	41%	⊙
Delmarva	51%	●	28%	⊙	84%	●	54%	⊙	41%	⊙
Kaiser[m]	51%	●	35%	●	73%	⊙	54%	●	48%	●
M.D. IPA	43%	⊙	28%	⊙	80%	●	46%	⊙	45%	⊙
OCI	35%	○	22%	○	72%	⊙	37%	○	40%	⊙
PHN	24%	○	15%	○	54%	○	33%	○	28%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- Combination 1 does not include the chicken pox vaccine (VZV).
- Combination 2 does include the chicken pox vaccine (VZV).

C. BREAST CANCER SCREENING

Background

After skin cancer, breast cancer is the most common type of cancer among women. It is also second only to lung cancer as a leading cause of cancer deaths among American women. Early identification and treatment of breast cancer can reduce significantly a woman's chance of dying from the disease. The American Cancer Society states the five-year survival rate from breast cancer is 98 percent, if it is detected early.

Mammograms are the most effective method for detecting breast cancer. A mammogram is an x-ray of the breast that can reveal tumors too small to be felt, and can show other changes in the breast that may suggest cancer. When high quality equipment is used and the x-rays are read by well-trained radiologists, 85 to 90 percent of cancers are detectable.

Breast cancer is most commonly found in women between 50 and 64 years old. The *Healthy People 2010* objective is to increase to at least 70 percent the proportion of women over 40 years old who had at least one mammogram during the past two years. Although there is continuing debate regarding the age at which screening mammography should start, there is consensus that women over 50 should be screened at least once every two years and that women under 50 should consult their provider regarding screening.

Definition of Measure

This measure shows what percent of commercially insured women age 50 through 69 years, who were continuously enrolled during 2000 and 2001, had a mammogram during 2000 or 2001.

Notes

This measure was eligible for HEDIS rotation in 2002. Because the majority of Maryland plans rotated this measure, individual rates were not included in the 2002 *Consumer Guide*, therefore, no plan was eligible for Star Performer designation.

Results

From 2000 to 2002, only one of the eight plans reporting for all three years improved its rate significantly. However, five of eight plans chose to "rotate" this measure, meaning their rates for 2001 and 2002 are identical.

The Maryland HMO/POS average increased four percentage points over this period. On average, 76 percent of women who should have received a mammogram received one. In 2002, eight plans received average scores and one plan was above average. Rates ranged from 72% to 84% (see Table 7).

Table 7

Breast Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**72%**	**75%**	**76%**	**4%**			
Aetna[r]	--	73%	73%	--	--	⊙	⊙
BlueChoice[r]	66%	79%	79%	↑	○	●	⊙
CIGNA[r]	72%	76%	76%	⇔	⊙	⊙	⊙
Coventry[r]	79%	84%	84%	⇔	●	●	●
Delmarva[m]	76%	74%	78%	⇔	●	⊙	⊙
Kaiser[m]	80%	78%	76%	↓	●	●	⊙
M.D. IPA	73%	71%	74%	⇔	⊙	○	⊙
OCI[r]	69%	73%	73%	⇔	⊙	⊙	⊙
PHN	77%	79%	72%	⇔	●	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2001**. All other plans used the hybrid method.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.
- No plan was eligible for Star Performer designation due to the majority of plans rotating the measure. A minority of plans reported new rates.

D. CERVICAL CANCER SCREENING

Background

When found and treated early, cervical cancer often can be cured. Cervical cancer used to be one of the most common causes of cancer death for American women. But between 1955 and 1992 the number of deaths from cervical cancer declined by 74 percent. The main reason for this change is the use of the Pap test to detected cervical cancer early.

Cervical cancer can be identified in its early stages by regular screening using a Pap smear test. The five-year survival rate for cervical cancer is 91 percent, if detected early.

The American College of Obstetricians and Gynecologists, the American Medical Association, and the American Cancer Society, recommend Pap testing every one to three years for all women who have been sexually active or who are over 18 years old. The *Healthy People 2010* objective is to increase to at least 90 percent the proportion of women age 18 and over who received at least one Pap smear during the past three years.

Definition of Measure

This measure shows what percent of commercially insured women age 21 through 64 years, who were continuously enrolled during 1999, 2000, and 2001, received one or more Pap tests during those years.

Notes

This measure was eligible for HEDIS rotation in 2002. Because the majority of Maryland plans rotated this measure, meaning a minority of plans reported new rates, individual rates were not included in the *2002 Consumer Guide*. No plan was eligible for Star Performer designation.

In 2001, the continuous enrollment requirements identified in the *HEDIS 2001, Volume 2: Technical Specifications* changed to require a member to be enrolled with the health plan for three years in order to qualify for inclusion in the measure. In 2000, the requirement was one-year of continuous enrollment. Given the increased continuity, this change may make it more likely that the member received the Pap test and/or the plan is more likely to be able to access administrative service information. This, in turn, will result in higher plan rates in the future.

When interpreting results, readers should be aware that the method a plan uses for excluding contraindications for this measure could potentially influence final results. Contraindications are situations when a member should be excluded from the measure. For example, women who have had a hysterectomy with no residual cervix could be excluded from the measure to detect cervical cancer. Plans have the option to exclude members who do not meet criteria to prevent the plan from appearing to perform less well.

Plans can search for contraindications in the entire population using administrative data only, exclude these members from the population file of people who meet criteria to receive the clinical care indicated, then draw a sample of those people who do meet the criteria (for the denominator of the measure). Alternatively, plans can search for contraindications after drawing the sample in both administrative data and the medical record. In either case, exclusions are made after determining whether or not people received the indicated clinical care and only members who did not receive the care are excluded (from the numerator)). Therefore, a member who has a contraindication but received care (has met the numerator criteria) would not be excluded. In this case, women who have had a hysterectomy are actually *more* likely to receive a Pap test. Therefore, depending on the number of exclusions, plans can influence their rates by the method of excluding contraindications they choose.

Results

From 2000 to 2002, six of the eight plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased ten percentage points over this period. However, five of eight plans chose to rotate this measure, meaning their rates for 2001 and 2002 are identical. For 2002, on average, 82 percent of women who should have received a pap smears received one. In 2002, seven plans received average scores, one plan was above average, and one plan was below average. Rates varied within a ten-point range, from 77% to 87% (see Table 8).

Table 8

Cervical Cancer Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**72%**	**81%**	**82%**	**10%**			
Aetna[r]	--	82%	82%	--	--	⊙	⊙
BlueChoice[r]	68%	81%	81%	↑	⊙	⊙	⊙
CIGNA[r]	73%	83%	83%	↑	⊙	⊙	⊙
Coventry[r]	63%	78%	78%	↑	○	⊙	⊙
Delmarva[m,r]	79%	77%	77%	↓	●	○	○
Kaiser[m]	87%	85%	87%	⇔	●	●	●
M.D. IPA	76%	83%	84%	↑	⊙	⊙	⊙
OCI	71%	81%	82%	↑	⊙	⊙	⊙
PHN	66%	84%	82%	↑	○	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2001**. All other plans used the hybrid method.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.
- No plan was eligible for Star Performer designation due to the majority of plans rotating the measure. A minority of plans reported new rates in 2002.

E. CHLAMYDIA SCREENING IN WOMEN

Background

Chlamydia is the most common sexually transmitted diseases (STDs) in the United States. People with chlamydia infections generally experience no symptoms or signs of infection. If left undetected and untreated, however, chlamydia infections in women often lead to pelvic inflammatory disease, infertility, ectopic pregnancy, and chronic pelvic pain. Reported rates for chlamydia are highest among women age 15 to 24.

Despite the wide availability of testing and treatment methods, chlamydia remains the most frequently reported STD in Maryland. The Maryland DHMH, Center for Community Epidemiology, attributed progress made in reducing chlamydia rates in this state to routine screenings in the 15 to 29 age group. It is the method that works.

Definition of Measure

This measure shows what percent of sexually active women age 16 to 20, age 21 to 26, (and total combined age 16 to 26) who were continuously enrolled during 2001, had at least one test for chlamydia during the measurement year.

Notes

All plans used the administrative method to calculate this rate. *HEDIS 2002, Volume 2: Technical Specifications* do not allow the use of the hybrid method.

The total combined age 16-26 measure was added in 2001 by MHCC. Therefore, only 2001 and 2002 results are reported here for this measure.

There are two methods to identify sexually active women for inclusion in the measure: through pharmacy data or through medical claims/encounter data. Changes to the *HEDIS 2001, Volume 2: Technical Specifications* require health plans to use both methods. In 2000, the *HEDIS 2000, Volume 2: Technical Specifications* indicated that health plans "should use both methods" **but this requirement was not mandatory**.

Several factors complicate calculating this measure and can influence results. When interpreting results, readers should consider the following:

- As indicated above, sexual activity is identified through pharmacy data or claims/encounter data. This method cannot identify all women who were sexually active, only those who received care related to sexual activity, such as prescriptions for contraceptives and pregnancy-related care. The actual number of women at risk is much larger than the number screened. The percent of women being screened by some plans is only a small fraction of those who meet the criteria for screening. Women meeting the criteria for screening, in turn, make up only a small percent of women at risk.
- Due to privacy issues, the number of chlamydia tests performed may be under-reported by providers.

Results

Consolidation of Aetna plans contributed significantly to a change in the Maryland HMO/POS average for this measure from 2000 to 2002. **Changes in the Maryland HMO/POS average should not be interpreted to arise solely from changes in plan performance**. See the Methodology section for further discussion.

From 2000 to 2002, the Maryland HMO/POS average increased by ten percentage points for the 16-20 year old age group (see Table 9) and by eight percentage points for the 21-26 year old age group (see Table 10). As noted above, changes in the *HEDIS 2001, Volume 2: Technical Specifications* regarding the identification of eligible members and the consolidation of Aetna plans contribute to these rate changes. Because the measure was new in 2000, this is the first year that the *Comprehensive Report* shows three years of trended data. No plans are eligible for Star Performer designation because the measure has been reported in the *2002 Consumer Guide* only once, in 2002.

In 2002, across both age groups (see Table 11), the average rate for screening is only 29%. Two plans received average scores, two plans were above average, and five plans were below average. Rates varied widely from 13 to 77%, possibly reflecting variations in data available from administrative systems as well as variations in quality of care. The measure requires improved performance by virtually every plan.

From 2001 to 2002, the Maryland HMO/POS average increased by one percentage point for the combined 16-26 year age group. Two plans received average scores, two plans were above average, and five plans were below average.

Table 9

Chlamydia Screening 16-20, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**21%**	**30%**	**31%**	**10%**			
Aetna	--	12%	15%	--	--	○	○
BlueChoice	7%	15%	24%	↑	○	○	○
CIGNA	23%	23%	33%	↑	⊙	○	⊙
Coventry	14%	37%	38%	↑	○	●	●
Delmarva	31%	27%	31%	⇔	●	⊙	⊙
Kaiser	43%	76%	77%	↑	●	●	●
M.D. IPA	21%	26%	21%	⇔	⊙	○	○
OCI	19%	23%	21%	⇔	○	○	○
PHN	34%	30%	21%	↓	●	⊙	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

Table 10

Chlamydia Screening 21-26, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**20%**	**27%**	**28%**	**8%**			
Aetna	--	9%	13%	--	--	○	○
BlueChoice	22%	23%	26%	↑	⊙	○	○
CIGNA	24%	32%	29%	↑	●	●	⊙
Coventry	17%	32%	31%	↑	○	●	●
Delmarva	22%	21%	27%	⇔	⊙	○	⊙
Kaiser	38%	73%	77%	↑	●	●	●
M.D. IPA	17%	19%	17%	⇔	○	○	○
OCI	16%	19%	19%	↑	○	○	○
PHN	33%	27%	15%	↓	●	⊙	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

Table 11

Chlamydia Screening Total, Trending				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2001	2002	2001	2002
Maryland HMO/POS Average	**28%**	**29%**		
Aetna	10%	13%	○	○
BlueChoice	21%	26%	○	○
CIGNA	29%	30%	●	⊙
Coventry	34%	34%	●	●
Delmarva	24%	28%	○	⊙
Kaiser	74%	77%	●	●
M.D. IPA	23%	19%	○	○
OCI	20%	20%	○	○
PHN	28%	17%	⊙	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- This measure was new in 2001. No plan is designated a star performer for this measure because it was reported in the *Consumer Guide* for the first time in 2002.

F. CONTROLLING HIGH BLOOD PRESSURE

Background

Heart disease is the leading cause of death for Americans. Heart disease and stroke are also leading causes of disability in the United States. High blood pressure is known as the "silent killer" because, although it is a major risk factor for coronary heart disease, stroke, and heart failure, it often causes no symptoms. It is estimated that 50 million Americans have high blood pressure. Many Americans with high blood pressure are not aware that they have this condition. Detection and treatment of high blood pressure improves cardiovascular health and may prevent fatal or debilitating cardiovascular events. The *Healthy People 2010* objective related to this measure is to increase to 50 percent the proportion of adults diagnosed with high blood pressure whose blood pressure is under control.

Definition of Measure

This measure assesses whether blood pressure was controlled among adult members with diagnosed hypertension. Members must be between the ages of 46 to 85 years, be continuously enrolled in 2001, and have had a diagnosis of hypertension. A member is considered "in control" if the most recent blood pressure reading indicates a representative systolic pressure less than or equal to 140 mmHg and a representative diastolic pressure less than or equal to 90 mmHg (less than or equal to BP of 140/90).

Notes

This measure was new in 2000, therefore, this is the first year for which three years of data are available. Because it has been reported in the *Consumer Guide* for three years, the measure is one for which plans can be designated as Star Performers.

Plans must use the hybrid method to calculate this measure.

In 2001, the HEDIS technical specifications changed to include blood pressures "**less than or equal to"** the thresholds of 140 mmHg and 90 mmHg. In 2000, blood pressure readings had to be **"less than"** these thresholds. This change, rather than improved quality, may be the cause of plans' generally higher rates in 2001 and 2002 compared to 2000.

Results

From 2000 to 2002, seven of the eight plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased by 15 percentage points (see Table 12), although on average, only 53% of members with hypertension had a reading of 140/90 or lower when last checked, even with the modified measure that is easier to achieve. As noted above, changes in the *HEDIS 2001, Volume 2: Technical Specifications* doubtlessly contribute to increases in rates. In 2002, four plans received average scores, four plans were above average, and one plan was below average. Rates varied widely from 5% to 71%, possibly reflecting data problems at one plan. One plan is recognized as a Star Performer.

Table 12

Controlling High Blood Pressure, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**38%**	**52%**	**53%**	**15%**			
Aetna[r]	--	63%	63%	--	--	●	●
BlueChoice	33%	38%	54%	↑	○	○	⊙
CIGNA	42%	62%	71%	↑	⊙	●	●
Coventry[r]	47%	54%	54%	↑	●	⊙	⊙
Delmarva	36%	42%	62%	↑	⊙	○	●
Kaiser	41%	49%	51%	↑	⊙	⊙	⊙
*M.D. IPA[r]	42%	60%	60%	↑	●	●	●
OCI[r]	37%	57%	57%	↑	⊙	⊙	⊙
PHN	37%	NR	5%	↓	⊙	NR	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NR = Not Reportable. Data did not pass independent audit.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

G. BETA BLOCKER TREATMENT AFTER A HEART ATTACK

Background

According to the American Heart Association, 1.1 million Americans will suffer a first or recurrent heart attack, or acute myocardial infarction (AMI) this year, and approximately 40 percent will die as a result. Those who have had a heart attack are at higher risk of having another. For approximately 450,000 of the 1.1 million Americans who will experience an AMI, it will not be the first. One medical therapy that has been shown to lower the risk is beta blocker treatment, which reduces both blood pressure and how hard the heart has to work.

Definition of Measure

This measure shows what percent of members age 35 years and older, who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction, were dispensed a prescription for beta blockers upon discharge.

Notes

It is important to consider that a number of plans cannot report the measure due to the low number of people they can identify as meeting the criteria for the measure. As *HEDIS 2002, Volume 2: Technical Specifications* direct, if the number of plan members who meet the criteria for the measure is less than 30, its rate is indicated by an NA ("Not Available"). The trending table for this measure reflects that NCQA convention.

As is true for the cholesterol management measure, codes used to identify an AMI require a high degree of specificity. Many plans do not receive sufficient specificity in codes submitted by providers to allow them to identify members who should receive these services. "NA" does not always mean that fewer than 30 members met criteria for beta blocker. "NA" could reflect a deficiency in data collection for these measures.

Results

From 2000 to 2002, one of the six plans reporting for all three years improved its rate significantly (see Table 13). The Maryland HMO/POS average increased 11 percentage points over this period. The average rate for all plans was 92 for 2002.

This measure has always been the measure that fewest plans can report. However, in 2002, seven of nine plans were able to identify enough members to report the measure. Four plans received average scores, two plans were above average, and one plan was below average. Two plans received "Not Available" designations. Rates varied from 83% to 100%. One plan was a Star Performer for this measure.

Table 13

Beta Blocker After Heart Attack, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**81%**	**88%**	**92%**	**11%**			
Aetna	--	96%	98%	--	--	●	●
BlueChoice	NA	NA	83%	NA	NA	NA	○
CIGNA	90%	95%	96%	⇔	●	●	⊙
Coventry	86%	86%	90%	⇔	⊙	⊙	⊙
Delmarva[m]	NA	NA	NA	NA	NA	NA	NA
*Kaiser	98%	98%	100%	⇔	●	●	●
M.D. IPA	81%	81%	90%	⇔	⊙	⊙	⊙
OCI	84%	83%	90%	↑	⊙	○	⊙
PHN	NA	68%	NA	NA	NA	○	NA

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

H. CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENTS

Background

High cholesterol is one of the leading causes of heart attacks among Americans. Those who have had a heart attack have a higher risk of having another. Two cardiac procedures are commonly used to reduce blockage of the arteries and to increase the flow of blood to the heart: coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA). Whether a member has had a heart attack or one of these cardiac procedures, regular monitoring and management of cholesterol levels, particularly LDL-C levels, is essential to reducing the risk of a heart attack.

Definition of Measure

The applicable population for this measure is all members age 18-75, who were hospitalized and discharged alive during the reporting year after an acute myocardial infarction (AMI), CABG, or PTCA. For these members, the following two rates are calculated:

- The percent who received a cholesterol (LDL-C) screening on or between 60 and 365 days after discharge,
- The percent who had a cholesterol (LDL-C) level of <130 mg/dL on or between 60 and 365 days after discharge.

Notes

Maryland plans were required to submit rates for cholesterol screening for the first time in 1999. In 2000, plans reported rates for cholesterol levels for the first time. Therefore, this year the 2000 to 2002 trend analyses are available for both the cholesterol screening and cholesterol control measures. As is true for the beta blocker measure, codes used to identify an AMI require a high degree of specificity. Many plans do not receive sufficient specificity in codes submitted by providers to allow identification of members who should receive these services. "NA" does not always mean that fewer than 30 members met criteria for screening and control. "NA" could reflect a deficiency in data collection for these measures.

Results

The Cholesterol Testing measure is eligible for Star Performer designation. However, since the Cholesterol Control is reported for the first time in the 2002 *Consumer Guide*, that measure is not eligible for consideration in determining Star Performer designations.

Cholesterol Testing

Comparison of 2000 to 2002 data indicate that two of the eight plans reporting for all three years improved their rates significantly (see Table 14). The Maryland HMO/POS average increased from 66% to 74%, eight percentage points over this period.

In 2002, six plans received average scores, two plans were above average, and one plan was below average. Rates ranged from 64% to 81%.

Cholesterol Control

From 2000 to 2002, four of the eight plans reporting for all three years improved their rates significantly. The Maryland HMO/POS average increased by 16 percentage points to 57% (see Table 15).

In 2002, six plans received average scores, two plans were above average, and one plan was below average. Rates varied from 25% to 73%.

Comparison of the testing and control rates across Maryland HMOs (see Table 16) indicate that, while 74% of members who had an acute cardiovascular event received a cholesterol test, only 57% had cholesterol levels that were known to be "in control."

Table 14

Cholesterol Management, Cholesterol (LDL-C) Screening, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**66%**	**72%**	**74%**	**8%**			
Aetna	--	61%	79%	--	--	○	●
BlueChoice	NA	77%	70%	NA	NA	⊙	⊙
CIGNA	65%	81%	78%	↑	⊙	●	⊙
Coventry	73%	63%	68%	⇔	⊙	○	⊙
Delmarva	85%	76%	71%	⇔	●	⊙	⊙
Kaiser[m]	72%	76%	77%	⇔	●	●	⊙
M.D. IPA	74%	72%	77%	⇔	●	⊙	⊙
OCI	68%	72%	81%	↑	⊙	⊙	●
PHN	67%	70%	64%	⇔	⊙	⊙	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- No plan achieved Star Performer status for this measure although the measure was eligible for such designation.

Table 15

Cholesterol Management, Cholesterol (LDL-C) Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**41%**	**51%**	**57%**	**16%**			
Aetna	--	44%	57%	--	--	⊙	⊙
BlueChoice	NA	62%	56%	NA	NA	●	⊙
CIGNA	39%	61%	63%		⊙	●	●
Coventry	61%	44%	55%	⇔	●	⊙	⊙
Delmarva	54%	29%	61%	⇔	⊙	○	⊙
Kaiser[m]	62%	64%	73%	↑	●	●	●
M.D. IPA	46%	53%	62%	↑	⊙	⊙	⊙
OCI	45%	53%	58%	↑	⊙	⊙	⊙
PHN	33%	NR	25%	⇔	⊙	NR	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- NR = Not Reportable. Data did not pass independent audit.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
- No plan was eligible to be designated a Star Performer for this measure because it was reported in the *Consumer Guide* for the first time in 2002.

Table 16

Cholesterol Management, Cholesterol (LDL-C) Screening and Control, 2002 Results				
	LDL-C Screening		LDL-C Control	
Maryland HMO/POS Average	**74%**		**57%**	
Aetna	79%	●	57%	⊙
BlueChoice	70%	⊙	56%	⊙
CIGNA	78%	⊙	63%	●
Coventry	68%	⊙	55%	⊙
Delmarva	71%	⊙	61%	⊙
Kaiser[m]	77%	⊙	73%	●
M.D. IPA	77%	⊙	62%	⊙
OCI	81%	●	58%	⊙
PHN	64%	○	25%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.

I. COMPREHENSIVE DIABETES CARE

Background

Diabetes affects over 15.7 million people or about 6 percent of the population in the United States, according to the American Diabetes Association. Approximately 5-10 percent of this population is insulin-dependent. The remainder has type II diabetes, which can be controlled through diet and/or medication. Diabetes is the seventh leading cause of death in the United States.

Diabetes is a chronic disease that has no cure. It can result in several debilitating or life-threatening complications including blindness, kidney disease, nerve disease and amputations, heart disease and stroke. It is important that the symptoms and complications of diabetes be closely monitored and addressed appropriately.

One of the most commonly accepted methods of determining whether a patient's diabetes is under control is measuring blood glucose level. Commonly, hemoglobin A1c (HbA1c) levels are monitored. This test provides a direct indication of blood glucose control.

Diabetes has been associated with cardiovascular diseases and individuals with diabetes have a 3 to 4-fold increase in risk for coronary artery disease. Lipid profiles should be regularly performed and the patient's cholesterol (LDL-C) level must be controlled. Diabetes is the leading cause of end-stage renal disease, accounting for 40 percent of new cases each year. Patients with diabetes should be monitored regularly for kidney disease. In addition, diabetes can result in degenerative eye diseases such as retinopathy, glaucoma, and cataracts. Diabetes is the leading cause of adult blindness in the United States. The American Diabetes Association estimates that each year 12,000 - 24,000 people with diabetes lose their sight. People with diabetes should have their eyes examined regularly so that appropriate treatment can be initiated at the first sign of a problem.

Definition of Measure

This measure, Comprehensive Diabetes Care, shows what percent of commercially insured members with diabetes (type I and type II), age 18-75, who were continuously enrolled during 2000, had each of the following:

- Blood Glucose (Hemoglobin A1c, HbA1c) tested
- Blood Glucose (HbA1c controlled) (<=9.5%)
- Cholesterol (LDL-C) tested
- Cholesterol (LDL-C) controlled (< 130 mg/dL)
- Eye exam (retinal)
- Kidney disease (nephropathy) monitored

Notes

For the Blood Glucose (HbA1c) Control measure, the HEDIS data set reports the percentage of members with HbA1c levels greater than 9.5%. While consensus may be lacking on what level constitutes "good control," most experts agree that HbA1c levels greater than 9.5% represent poor control. The rates presented in the tables that follow show the percent of members with HbA1c levels that are less than or equal to 9.5% (i.e., the percent of members "in control"). A higher rate indicates better performance.

Methods used to identify members with diabetes can influence final rates. In 2001 and 2002, NCQA required plans to identify people with diabetes using pharmacy data and encounter data (i.e., "claims" sent to the plan when a member sees a provider). In 2000, plans were not required to use both methods.

Use of pharmacy data alone tends to exclude people with type II diabetes since medication is not always necessary. Type I diabetics are at higher risk for degenerative eye disorders. Typically, relying on encounter data alone tends to find more false positives, or members who are incorrectly identified as having diabetes. This causes rates for those plans to be under-reported. Use of both methods in 2001 and 2002 may improve the accuracy of the denominator (the number of people who should have received the care in question) used to calculate the rate for each plan.

Results

From 2000 to 2002, the Blood Glucose (HbA1c) Testing rate increased seven percentage points, the Eye Exam rate increased five percentage point, the Cholesterol Testing measure increased 17 percentage points, and the Monitoring for Diabetic Nephropathy measure increased by 11 percentage points (see Tables 17, 19, 20 and 22). All of these measures simply require providing monitoring/testing services to patients.

In contrast, the Blood Glucose (HbA1c) Control measure reveals that the number of people with HbA1c levels of less than or equal to 9.5% increased by 10 percentage points. The percentage of members whose cholesterol levels were controlled, as reflected by the Cholesterol Control measure, increased 13 percentage points (see Tables 18 and 21). These measures are intermediate outcome measures that reflect the impact of managing this chronic disease. As such, they are recognized to be complex and dependent upon proper treatment, ongoing monitoring, and patient cooperation to achieve optimum results.

In 2002, across Maryland plans, rates for the Blood Glucose (HbA1c) and Cholesterol testing measures were significantly higher (81% and 83%) than rates for the corresponding control measures (see Table 23). Rates for control measures, Blood Glucose (HbA1c) and Cholesterol (LDL-C) Control, were 61% and 52% respectively.

Two plans rotated the Glucose Testing measure and three plans rotated the Glucose Control and Nephropathy measures. This means those rates reflect 2000 performance and they are identical to the rates reported in 2001.

In 2002, health plan rates varied widely within each of the Comprehensive Diabetes Care's six measures as follows:

Measure	Highest Percentage Rate	Lowest Percentage Rate
Blood Glucose Testing	85%	70%
Blood Glucose Control	76%	15%
Eye Exams	76%	38%
Cholesterol Testing	88%	75%
Cholesterol Control	70%	18%
Monitoring Diabetic Nephropathy	78%	28%

This report does not show the percentage of members in each plan that received all of the interventions that are known to be critically important in the control of diabetes. However, in order to get an accurate picture of diabetes care, that next step is needed. Just as adequate immunization depends on children receiving all of the individual vaccines that are needed, so too does care of complex chronic disease depend upon receipt of all components of care.

Table 17

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**74%**	**77%**	**81%**	**7%**			
Aetna	--	80%	83%	--	--	⊙	⊙
BlueChoice[r]	74%	83%	83%	↑	⊙	●	⊙
CIGNA	79%	79%	84%	⇔	●	⊙	⊙
Coventry[r]	73%	80%	80%	↑	⊙	⊙	⊙
Delmarva	77%	83%	85%	↑	⊙	●	●
Kaiser	84%	71%	85%	⇔	●	○	●
M.D. IPA	77%	80%	82%	⇔	⊙	⊙	⊙
OCI	73%	78%	82%	↑	⊙	⊙	⊙
PHN	71%	65%	70%	⇔	⊙	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- No plan achieved Star Performer status for this measure although the measure was eligible for such designation.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

Table 18

Comprehensive Diabetes Care, Blood Glucose (HbA1c) Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**51%**	**59%**	**61%**	**10%**			
Aetna	--	59%	60%	--	--	⊙	⊙
BlueChoice[r]	46%	71%	71%	↑	○	●	●
CIGNA	56%	52%	66%	↑	⊙	○	●
Coventry[r]	52%	64%	64%	↑	⊙	●	⊙
Delmarva[r]	58%	76%	76%	↑	●	●	●
Kaiser	65%	56%	64%	⇔	●	⊙	⊙
M.D. IPA	57%	62%	68%	↑	●	⊙	●
OCI	50%	61%	66%	↑	⊙	⊙	●
PHN	37%	33%	15%	↓	○	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- No plan was eligible to be designated a Star Performer for this measure because it was reported in the *Consumer Guide* for the first time in 2002.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

Table 19

Comprehensive Diabetes Care Eye Exams, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**45%**	**46%**	**50%**	**5%**			
Aetna	--	46%	51%	--	--	⊙	⊙
BlueChoice[r]	44%	53%	53%	↑	⊙	●	⊙
CIGNA	37%	40%	41%	⇔	○	○	○
Coventry[r]	45%	58%	58%	↑	⊙	●	●
Delmarva	41%	41%	44%	⇔	⊙	○	○
*Kaiser	82%	63%	76%	↓	●	●	●
M.D. IPA	49%	47%	47%	⇔	⊙	⊙	⊙
OCI	38%	43%	45%	⇔	○	⊙	○
PHN	29%	35%	38%	↑	○	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001
- * Star Performer - this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

Table 20

Comprehensive Diabetes Care Cholesterol Testing, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**66%**	**77%**	**83%**	**17%**			
Aetna	--	74%	80%	--	--	⊙	⊙
BlueChoice	66%	76%	83%	↑	⊙	⊙	⊙
CIGNA	78%	80%	87%	↑	●	⊙	●
Coventry[r]	73%	82%	82%	↑	●	●	⊙
*Delmarva	80%	87%	88%	↑	●	●	●
Kaiser	70%	73%	85%	↑	⊙	⊙	⊙
M.D. IPA	76%	83%	84%	↑	●	●	⊙
OCI	74%	75%	86%	↑	●	⊙	⊙
PHN	33%	64%	75%	↑	○	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- * Star Performer - this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

Table 21

Comprehensive Diabetes Care Cholesterol Control, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**39%**	**43%**	**52%**	**13%**			
Aetna	--	45%	48%	--	--	⊙	⊙
BlueChoice	37%	47%	59%	↑	⊙	⊙	●
CIGNA	43%	41%	56%	↑	⊙	⊙	⊙
Coventry[r]	48%	48%	48%	⇔	●	●	⊙
Delmarva	41%	30%	70%	↑	⊙	○	●
Kaiser	44%	47%	64%	↑	⊙	⊙	●
M.D. IPA	37%	45%	55%	↑	⊙	⊙	⊙
OCI	36%	43%	51%	↑	⊙	⊙	⊙
PHN	68%	NR	18%	↓	●	NR	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NR = Not Reportable. Data did not pass independent audit.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.
- No plan was eligible to be designated a Star Performer for this measure because it was reported in the *Consumer Guide* for the first time in 2002.

Table 22

Comprehensive Diabetes Care Monitoring Diabetic Nephropathy, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**36%**	**41%**	**47%**	**11%**			
Aetna[r]	--	50%	50%	--	--	●	⊙
BlueChoice[r]	32%	28%	28%	⇔	⊙	○	○
CIGNA	26%	31%	44%	↑	○	○	⊙
Coventry[r]	29%	57%	57%	↑	○	●	●
Delmarva	68%	44%	66%	⇔	●	⊙	●
Kaiser	68%	63%	78%	↑	●	●	●
M.D. IPA	22%	30%	36%	↑	○	○	○
OCI	23%	35%	34%	↑	○	○	○
PHN	28%	28%	34%	⇔	○	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ **Plan's rate decreased significantly from 2000 to 2002**

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.
- No plan was eligible to be designated a Star Performer for this measure because it was reported in the *Consumer Guide* for the first time in 2002.

Table 23

Comprehensive Diabetes Care, 2002 Results												
	HbA1c Testing		HbA1c Control		Eye Exams		Cholesterol Testing		Cholesterol Control		Monitoring Diabetic Nephropathy	
Maryland HMO/POS Average	**81%**		**61%**		**50%**		**83%**		**52%**		**47%**	
Aetna	83%	⊙	60%	⊙	51%	⊙	80%	⊙	48%	⊙	50%	⊙
BlueChoice	83%	⊙	71%	●	53%	⊙	83%	⊙	59%	●	28%	○
CIGNA	84%	⊙	66%	●	41%	○	87%	●	56%	⊙	44%	⊙
Coventry	80%	⊙	64%	⊙	58%	●	82%	⊙	48%	⊙	57%	●
Delmarva	85%	●	76%	●	44%	○	88%	●	70%	●	66%	●
Kaiser	85%	●	64%	⊙	76%	●	85%	⊙	64%	●	78%	●
M.D. IPA	82%	⊙	68%	●	47%	⊙	84%	⊙	55%	⊙	36%	○
OCI	82%	⊙	66%	●	45%	○	86%	⊙	51%	⊙	34%	○
PHN	70%	○	15%	○	38%	○	75%	○	18%	○	34%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

J. USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA

Background

According to the American Lung Association, over 17 million people suffer from asthma, making it the seventh leading chronic condition in the United States. Asthma can be a life-threatening disease if not managed properly. Specific medications, such as corticosteroids, have been identified as being the most effective therapy to control persistent asthma. Many people do not receive appropriate therapy.

Definition of Measure

This measure shows what percent of members, age 5-56 who were continuously enrolled during 2000 and 2001, with persistent asthma were prescribed medications acceptable as primary therapy for long-term control of asthma. People with persistent asthma are defined by HEDIS as having had **any** of the following in 2000 (the year prior to the measurement year):

- at least four asthma medication dispensing events, or
- at least one Emergency Department visit with asthma as the principal diagnosis, or
- at least one hospitalization with asthma as the principal diagnosis, or
- at least four outpatient visits with asthma as one of the listed diagnoses and a minimum of two asthma dispensing events.

The medications identified as acceptable primary therapy are listed on the NCQA's Web site.

Results

This measure was reported publicly for the first time in 2000; therefore, three years of performance data are now available and plans were considered for Star Performer designation for the measure in 2002.

Results are broken down into three age groups: age 5-9, age 10-17, and age 18-56. Results are also presented for the total population across all age groups.

For 2002, the Maryland HMO/POS average is similar across all three age groups at 68% (age 5-9), 61% (age 10-17) and 63% (age 18-56) (see Table 25). One plan's "NA" for all children does not necessarily reflect that fewer than 30 children in each age group met the criteria for asthma treatment. Data deficiencies may have prevented the identification of members who should have been included.

However, plan relative performance did vary by age group. The Maryland HMO/POS average for the total population across all age groups increased six percentage points from 57% in 2000 to 63% for 2002 (see Table 24).

In 2002, three plans received average scores, two were above average and three were below average. One plan received "Not Report."

Among the plans, the percent of people with asthma who receive appropriate treatment varied from about half to almost three quarters (54% to 72%).

Table 24

Medications Used for Asthma - Combined Age Groups, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**57%**	**61%**	**63%**	**6%**			
Aetna	--	65%	66%	--	--	●	●
BlueChoice	35%	71%	NR	NR	○	●	NR
CIGNA	62%	66%	66%	⇔	●	●	⊙
Coventry	64%	58%	64%	⇔	●	⊙	⊙
Delmarva	40%	35%	65%	↑	○	○	⊙
Kaiser	49%	61%	72%	↑	○	⊙	●
M.D. IPA	69%	67%	57%	↓	●	●	○
OCI	66%	66%	54%	↓	●	●	○
PHN	51%	NR	58%	⇔	○	NR	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NR = Not Reportable. Data did not pass independent audit.
- No plan achieved Star Performer status for this measure although the measure was eligible for such designation.

Table 25

Medications Used for Asthma, 2002 Results								
	Age 5-9		Age 10-17		Age 18-56		Ages Combined	
Maryland HMO/POS Average	**68%**		**61%**		**63%**		**63%**	
Aetna	67%	⊙	62%	⊙	67%	●	66%	●
BlueChoice	NR	NR	50%	○	66%	●	NR	NR
CIGNA	64%	⊙	63%	⊙	67%	●	66%	⊙
Coventry	69%	⊙	63%	⊙	63%	⊙	64%	⊙
Delmarva	NA	NA	NA	NA	62%	⊙	65%	⊙
Kaiser	68%	⊙	64%	●	77%	●	72%	●
M.D. IPA	73%	⊙	67%	●	53%	○	57%	○
OCI	71%	⊙	64%	⊙	50%	○	54%	○
PHN	62%	⊙	51%	○	59%	⊙	58%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- NR = Not Reportable. Data did not pass independent audit.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

K. FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Background

According to the National Institute for Mental Health, a significant portion of the population experiences some form of mental illness (including major depression, obsessive-compulsive disorder, and schizophrenia). Because mental illness symptoms vary by diagnosis and stigma persists with behavioral disorders, only a small portion of the population is diagnosed.

Suicide, the most serious risk to those with mental illness, is the eleventh leading cause of death and third among 15-24 year olds (http://www.cdc.gov/nchs/fastats/suicide.htm.) Almost all individuals who commit suicide have a diagnosable mental disorder.

In addition, the economic cost of mental disorders (as measured in terms of days lost from work and cost of treatment) was estimated at $480 million in 1990. Over the course of their lives, many people, although a small percent of the total population, experience some form of mental illness that leads them to be hospitalized. And many people who have mental disorders need to be hospitalized from time to time. Hospitalization is one important component of a wide range of services used to address mental health conditions. To help ensure the benefits of hospitalization are sustained, patients should receive follow-up visits with a mental health practitioner beginning shortly after hospital discharge. Contact within seven days is important to ensure the patient has the necessary supports to make the transition home and to help prevent hospital readmission during this period of high risk for relapse or decline. An outpatient visit with a mental health practitioner within 30 days of discharge can help the patient manage in the longer term. This may include medication adjustment and the development of psychological and social supports.

Definition of Measure

This measure shows what percent of plan members (age six years and older) hospitalized for treatment of selected mental health disorders were seen on an ambulatory basis or were in day/night treatment within 7 and 30 days of hospital discharge.

Notes

Since the 7-day measure was not reported in the *2000 Consumer Guide*, Star Performer designations were not awarded for this measure. The 30-day measure is eligible for Star Performer designation.

Several factors complicate calculating this measure and can lead to under-reporting. When interpreting results, readers should consider the following:

- Since hospitalizations for mental illness do not occur frequently, the numbers of people who should have received the services measured, are often small.
- Mental health services are often not administered by HMO providers. Both HMOs and employers contract with external organizations, managed behavioral health care organizations (MBHOs), to provide mental health services. HMOs do not always receive complete data from their vendors. Incomplete or missing data can often influence HMOs' ability to accurately calculate this measure. However, HMOs are legally responsible for care provided by their contractors and data associated with the provision of that care.
- Health plans may not integrate information from their external contractors and their own network providers. In 2002, HEDIS auditors found that several plans did not consider antidepressant medication prescribed by (or visits with) primary care providers that members used within the plan's own network.

Results

From 2000 to 2002, only one plan was able to improve its rate significantly for the 30-day measure and no plans improved significantly for the 7-day measure (see Tables 26 and 27). **Of all the Effectiveness of Care measures, this measure showed the least improvement over time.** In 2002, for the 30-day measure, seven plans received average scores, one plan was above average, and no plans were below average. One plan received a "Not Available" designation. This may reflect a data collection or reporting failure that prevented the plan from identifying members who met the criteria. Is does not necessarily mean that fewer than 30 people in the entire plan were eligible to receive these services.

Rates ranged from 70% to 80% for the 30-day measure. One plan was a Star Performer for the 30-day measure.

For the 7-day measure, the average for all plans was much lower, 52%, and actually showed a decline of one percentage point since 2001. Three plans received average scores, three plans were above average, and two plans were below average. For follow-up within 7days of hospital discharge, plan performance ranged from 20% to 69%.

Comparison of the rates for the two measures (see Table 28) indicates that, in 2002 across Maryland HMOs, 76% of eligible members received a follow-up visit within 30 days. Only 52% of members who should have received a visit within 7 days of hospital discharge did receive a visit.

Table 26

Follow-up After Hospitalization for Mental Illness, 7 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**53%**	**48%**	**52%**	**-1%**			
Aetna	--	50%	58%		--	⊙	●
BlueChoice[m]	39%	20%	20%	🡻	○	○	○
CIGNA[m]	55%	56%	56%	⇔	⊙	●	⊙
Coventry	59%	38%	45%	⇔	⊙	○	○
Delmarva[m]	74%	NA	60%	⇔	●	NA	⊙
Kaiser[m]	66%	60%	69%	⇔	●	●	●
M.D. IPA[m]	52%	57%	59%	⇔	⊙	●	●
OCI[m]	55%	55%	51%	⇔	⊙	●	⊙
PHN[m]	42%	41%	NA	NA	⊙	⊙	NA

Legend:

Change 2000 – 2002

- 🡹 Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- 🡻 Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
- No plan was eligible to be designated a Star Performer for this measure because it was reported in the *Consumer Guide* for first time in 2001.

Table 27

Follow-up After Hospitalization for Mental Illness, 30 Days, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**72%**	**70%**	**76%**	**4%**			
Aetna	--	73%	79%	--	--	⊙	⊙
BlueChoice[m]	61%	78%	75%	↑	⊙	●	⊙
CIGNA[m]	73%	70%	70%	⇔	⊙	⊙	⊙
Coventry	74%	62%	73%	⇔	⊙	○	⊙
Delmarva[m]	88%	NA	77%	⇔	●	NA	⊙
*Kaiser[m]	80%	75%	80%	⇔	●	●	●
M.D. IPA[m]	77%	75%	75%	⇔	⊙	●	⊙
OCI[m]	74%	75%	75%	⇔	⊙	●	⊙
PHN[m]	67%	59%	NA	NA	⊙	○	NA

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001 and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.
- [m] These plans used the administrative method to calculate this rate **in 2002**. All other plans used the hybrid method.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.

Table 28

Follow-up After Hospitalization for Mental Illness, 2002 Results				
	7 Days		30 Days	
Maryland HMO/POS Average	**52%**		**76%**	
Aetna	58%	●	79%	⊙
BlueChoice	20%	○	75%	⊙
CIGNA[r]	56%	⊙	70%	⊙
Coventry	45%	○	73%	⊙
Delmarva	60%	⊙	77%	⊙
Kaiser	69%	●	80%	●
M.D. IPA	59%	●	75%	⊙
OCI	51%	⊙	75%	⊙
PHN	NA	NA	NA	NA

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

L. ANTIDEPRESSANT MEDICATION MANAGEMENT

Background

According to the National Institute for Mental Health, 19 million adults age 18 and older suffer from depression, the most common mental disorder. Although depression affects 10% of adults every year, only half of patients receive appropriate treatment and comply with treatment regimens. An estimated 35 percent of people suffering from depression are receiving no treatment, based on 2001 findings by the Robert Wood Johnson Foundation and the Foundation for Accountability.

Once diagnosed, depression can be effectively treated with medication. Antidepressants can have side effects and treatment must be monitored to ensure effectiveness.

Definition of Measure

This measure assesses three different facets of successful pharmacological management of depression.

1) *Optimal Practitioner Contacts for Medication Management*: Percent of plan members age 18 and older, newly-diagnosed with depression, and treated with antidepressant medication, who had at least three follow-up contacts with an appropriate health care provider, at least one of which is with a prescribing practitioner, during an 84-day acute treatment phase.

2) *Effective Acute Phase Treatment*: Percent of plan members age 18 and older, newly-diagnosed with depression, and treated with antidepressant medication, who remained on antidepressant medication during an 84-day acute treatment phase.

3) *Effective Continuation Phase Treatment*: Percent of plan members age 18 and older newly-diagnosed with depression and treated with antidepressant medication, who remained on an antidepressant medication for at least 180 days.

Notes

Like the two measures for follow-up after hospitalization for a mental disorder, some unique issues may affect these three measures. Coordinating data collection may pose a large challenge. Six of the nine Maryland plans contract with another entity, a managed behavioral health organization (MBHO) to provide behavioral health benefits to members. Individual employers often contract with a different organization for behavioral health services (which typically include mental health and chemical dependency care) than they use for health services. Prescription drug plans are also often separate from health plan membership. When the employer rather than the health plan

contracts with a drug benefit company, the health plan does not have information on member drug use. In cases where the health plan has no contractual relationship with the providers of behavioral health services, or drug benefits, the plan only would have data for the services member received through the plan network. Even when the health plan holds the contract with other providers and can request data, integrating data from the plans own providers and from outside contracts adds an additional step to data collection efforts and may result in the omission of some data.

Because seeing a non-physician, such as a social worker or psychologist, may be more affordable (and available) for members, the logistics of also paying to see a physician who can prescribe and adjust antidepressants may decrease the rate for the optimal provider contact measure. It may also reduce members' access to antidepressants.

Results

Following the lead of the NCQA, MHCC did not report data for this multi-part measure in 2001, due to problems in the data collection specifications developed by NCQA.

Because of the problem in 2001, plans were not considered for Star Performer designation for the measure, or its component parts, and only 2002 results are reported here (see Table 29).

Optimal Practitioner Contacts for Medication Management:

In 2002, three plans received average scores, two plans were above average, and three plans were below average. Rates ranged from 10% to 31%. One plan received an NA for this measure.

Effective Acute Phase Treatment:

In 2002, seven plans received average scores, one plan was above average, and no plans were below average. Rates ranged from 55% to 66%. One plan received an NA for this measure.

Effective Continuation Phase Treatment:

In 2002, one plan was above average, five plans received average scores and two plans were below average. Rates ranged from 32% to 46%. One plan received an NA for this measure.

Regarding the plan that received NA designations for all components of this measure, it should not be presumed that fewer than 30 members met the criteria to receive the anti-depressant care described here. Deficiencies in data systems may have prevented the plan from identifying eligible members.

Table 29

Antidepressant Medication Management, 2002 Results						
	Optimal Practitioner Contacts		Effective Acute Phase Treatment		Effective Continuation Phase	
Maryland HMO/POS Average	**21%**		**59%**		**39%**	
Aetna	21%	⊙	57%	⊙	40%	⊙
BlueChoice	16%	○	58%	⊙	32%	○
CIGNA	17%	⊙	55%	⊙	32%	○
Coventry	27%	⊙	59%	⊙	41%	⊙
Delmarva	10%	○	66%	⊙	45%	⊙
Kaiser	16%	○	63%	●	46%	●
M.D. IPA	31%	●	58%	⊙	36%	⊙
OCI	29%	●	56%	⊙	37%	⊙
PHN	NA	NA	NA	NA	NA	NA

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- NA = Not Available. The plan could not report this number because an insufficient number of members were included in the rate to allow for plan comparisons.
- No plan was designated as a Star Performer for this series of measures, since rates were not publicly reported in 2001.

M. FLU SHOTS FOR ADULTS 50-64 (NEW MEASURE)

Background

This new measure looks at the percentage of members age 50-64 who received an influenza vaccination during the previous flu season. Developed in collaboration with the CDC, this measure is based on a response item in the HEIDS/CAHPS® 2.0H Adult Commercial Survey. The specifications for this measure are consistent with current recommendations from the Advisory Committee on Immunization Practices.

The burden of influenza-related morbidity and mortality among persons 50-64 is significant. Hospitalization rates for persons in this age group have varied between 80 and 400 per 100,000 for those with high-risk conditions and from approximately 20 to 40 per 100,000 for those without such conditions. Of the 20,000 influenza-associated deaths per year, about nine percent occur among persons ages 50-64. The disease burden for influenza is large and the potential for prevention is high. Influenza infections result in significant health care expenditures each year and vaccination is safe and effective.

Notes

This is a new measure in HEDIS 2002.

Results

In 2002, the Maryland HMO/POS average was 46%. One plan was above average, seven plans received average scores and one plan was below average. Rates ranged from 36% to 57% (see Table 30).

Table 30

Flu Shots for Adults 50-64, 2002 Results		
	Age 50-64	
Maryland HMO/POS Average	**46%**	
Aetna	41%	⊙
BlueChoice	44%	○
CIGNA	36%	⊙
Coventry	50%	⊙
Delmarva	46%	⊙
Kaiser	57%	●
M.D. IPA	51%	⊙
OCI	41%	⊙
PHN	47%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- No plan was designated as a Star Performer for this series of measures, since this is a first year measure.

ACCESS/AVAILABILITY OF CARE

IV. ACCESS/AVAILABILITY OF CARE

Summary

This section presents results for the Access/Availability of Care measures that MHCC required Maryland HMOs to report in 2002. The measures estimate the levels of access members have to their health care delivery systems.

Measure	Description
Adults' Access to Preventive/ Ambulatory Health Services	The percent of adult members age 20-44, and 45-64 who had at least one ambulatory or preventive care visit in the past three years.
Children's Access to Primary Care Providers	The percent of children age 12 through 24 months, 25 months through 6 years who had at least one visit with a health plan primary care provider in the past year. And the percent of children age 7 years through 11 years who had a visit with a health plan primary care provider in the past two years.
Prenatal and Postpartum Care	The percent of women who delivered a live birth during 2001 who had a prenatal visit during the first trimester **or** a visit within 42 days of joining the plan, if the patient wasn't continuously enrolled during the first trimester. And the percent of women who delivered a live birth in 2001 who had a postpartum visit with an appropriate medical practitioner 21-56 days after delivery.

Adults' Access and Children's Access

The Adults' Access and Children's Access measures are calculated using administrative data only.

As an estimate of the access members have to primary care services, the Adults' Access and Children's Access measures indicate the percentage of the plan's population who saw a practitioner within a specified period of time. It should be noted, however, that the reason a member did not receive care cannot always be linked to access problems. Members may feel that they do not need medical services or may not choose to obtain services. Obtaining an accurate measurement of access to care is a continuing challenge in quality measurement. These HEDIS measures act as proxies for access.

It should also be noted that the Adults' and Children's Access measure examines primary care, which is often capitated in a managed care environment. Under a capitated payment system, primary care providers (PCPs) receive a fixed payment per month for each member assigned to them. In general, this payment is received regardless of the number of services rendered by the provider. As a result, capitated providers do not have a financial incentive to submit encounter data since they do not receive payment for each

patient encounter as they would when submitting claims in a fee-for-service environment. Issues of data completeness can affect results for the Adults' and Children's Access measures.

Quantifying data completeness is particularly difficult since numerous issues can result in a lower-than-expected rate of visits. A low access rate could signify data submission issues with providers, barriers to care for members, or a healthy population that does not need much medical treatment.

All of these factors complicate interpreting rates when considering issues of access. However, when access rates are combined with other information, these data can provide valuable information to consumers, purchasers, policy makers, and other stakeholders in health care.

Prenatal and Postpartum Care

The Prenatal and Postpartum Care measure was new in 2001. It essentially replaced both the Check-Ups After Delivery (or Check-Ups for New Moms as the measure is called in the *Consumer Guide*) and Prenatal Care in the First Trimester measures that were part of the HEDIS 2000 measurement set.

Plans can use either the administrative or hybrid method to calculate the Prenatal and Postpartum Care measure.

A. ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES

Background

The U.S. Public Health Service's Task Force on Prevention recommends that even healthy adults receive some important preventative services at least once every three years.

Definition of Measure

This measure shows what percent of members age 20-44 and 45-64 years had at least one ambulatory or preventive care visits during reporting years 2000, 2001, or 2002.

Notes

Since MHCC has required that plans report this measure since 1998, several plans with data completeness problems have continued to show improvement over the course of reporting. Increases in reported rates may be attributable to improvements in data completeness rather than improved access to care for members.

The relatively high number of plans considered above or below average is partially a result of the fact that this measure is calculated on administrative data only. Since samples are not used, the number of people who meet criteria for the measure (constituting the denominator) is relatively large and confidence intervals are small, increasing the likelihood that variations in plan rates are statistically significant.

The Adults' Access measure is reported for two age groups: age 20-44 and age 45-64. In 1999 and 2000, the rates for these age groups were reported separately in the *Consumer Guide*. Because relative plan performance was identical across both age groups in 2001, MHCC reported combined results for the Adults' Access measure for age 20-64. Trending information is included in this report for both the 20-44 and 45-64 age groups. Because the two age groups were combined for 2001 and 2002, only a combined rate is available for adults 20-64.

Results

Plans **cannot** achieve Star Performer status for this measure. Because rates have remained consistently level, this measure was not reported in the 2002 *Consumer Guide*. Inclusion in the current year's guide is a key criterion for consideration as a Star Performer.

Age 20 through 44

From 2000 to 2002, seven of the eight plans reporting for all three years improved their rates significantly (see Table 31). The Maryland HMO/POS average increased four percentage points over this period. In 2002, one plan received an average score, four plans were above average, and four plans were below average. Rates ranged from 89% to 95%.

Age 45 through 64

Consistent with the results for the 20 through 44 age group from 2000 to 2002, six of the eight plans reporting for all three years improved their rates significantly (see Table 32). The Maryland HMO/POS average increased three percentage points over this period. In 2002, one plan received an average score, four plans were above average, and four plans were below average. Rates ranged narrowly from 91% to 96%.

Combined Measure: Age 20 through 64

From 2001 to 2002, the Maryland HMO/POS average increased one percentage point. In 2002, no plan received an average score, five plans were above average, and four plans were below average (see Table 33). Rates ranged very narrowly from 90% to 95%, indicating all plans provide at least one preventive or ambulatory visit to most adults over a three-year period.

Table 31

Adults' Access to Preventive/Ambulatory Health Services (Ages 20-44), Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**88%**	**91%**	**92%**	**4%**			
Aetna	--	90%	91%	--	--	⊙	○
BlueChoice	86%	88%	89%	↑	○	○	○
CIGNA	86%	87%	89%	↑	○	○	○
Coventry	93%	93%	94%	↑	●	●	●
Delmarva	93%	92%	92%	⇔	●	●	⊙
Kaiser	90%	93%	95%	↑	●	●	●
M.D. IPA	91%	93%	93%	↑	●	●	●
OCI	89%	92%	92%	↑	●	●	○
PHN	90%	93%	94%	↑	●	●	●

Legend:

Change 2000 – 2002

↑ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000 - 2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

Table 32

Adults' Access to Preventive/Ambulatory Health Services (Ages 45-64), Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**91%**	**93%**	**94%**	**3%**			
Aetna	--	93%	93%	--	--	○	○
BlueChoice	88%	93%	93%	↑	○	○	○
CIGNA	89%	89%	91%	↑	○	○	○
Coventry	94%	95%	95%	⇔	●	●	●
Delmarva	96%	95%	96%	⇔	●	●	●
Kaiser	94%	95%	96%	↑	●	●	●
M.D. IPA	93%	94%	94%	↑	●	●	⊙
OCI	91%	94%	94%	↑	●	●	○
PHN	92%	94%	95%	↑	●	●	●

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000 - 2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

Table 33

Adults' Access to Preventive/Ambulatory Health Services (Ages 20-64), Trending				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2001	2002	2001	2002
Maryland HMO/POS Average	**92%**	**93%**		
Aetna	91%	92%	○	○
BlueChoice	90%	91%	○	○
CIGNA	88%	90%	○	○
Coventry	94%	94%	●	●
Delmarva	94%	94%	●	●
Kaiser	94%	95%	●	●
M.D. IPA	94%	94%	●	●
OCI	93%	93%	●	○
PHN	93%	94%	●	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- No plan could be designated a Star Performer for the combined access measure because 2001 was the first year the measure was reported this way.

Table 34

Adults' Access to Preventive/Ambulatory Health Services , All Measures, 2002 Results						
	20-44 Years		45-64 Years		20-64 Years	
Maryland HMO/POS Average	**92%**		**94%**		**93%**	
Aetna	91%	○	93%	○	92%	○
BlueChoice	89%	○	93%	○	91%	○
CIGNA	89%	○	91%	○	90%	○
Coventry	94%	●	95%	●	94%	●
Delmarva	92%	⊙	96%	●	94%	●
Kaiser	95%	●	96%	●	95%	●
M.D. IPA	93%	●	94%	⊙	94%	●
OCI	92%	○	94%	○	93%	○
PHN	94%	●	95%	●	94%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

B. CHILDREN'S ACCESS TO PRIMARY CARE PROVIDERS

Background

Similar to the Adults' Access to Preventive/Ambulatory Health Services measure, this measure shows whether children had a least one visit to a provider as a way to determine a minimum level of access to care for children. All visits to pediatricians, family physicians, and other health plan primary care providers are counted for this measure.

Definition of Measure

This measure shows the percent of children:

- Age 12-24 months and age 25 months through 6 years continuously enrolled in 2001 who had at least one visit to a primary care provider during this measurement year.
- Age 7-11 years continuously enrolled during 2000 and 2001 who had at least one visit to a primary care provider during 2000 or 2001.

Notes

Because the threshold for these measures is so low, and all plans reported rates in the mid- to high-90s for at least the youngest age group, these measures are not reported in the *Consumer Guide.* Plans **cannot** achieve Star Performer status for these measures.

Results

Rates for these measures are high and most plans are improving. Rates tend to decrease from the youngest age group to the oldest, meaning older children see providers less frequently. Within the 7 to 11 age group, two plans reported 17 and 18 percent of children respectively did not have even one visit with a provider during an entire year (see Table 37).

Age 12 through 24 Months

From 2000 to 2002, five of the eight plans reporting for all three years significantly improved their rates, while no plan experienced a decrease (see Table 35). The Maryland HMO/POS average increased five percentage points over this period.

In 2002, four plans received average scores, two plans were above average, and three plans were below average. Rates ranged very narrowly from 94% to 99%.

Age 25 Months through 6 Years

From 2000 to 2002, six of the eight plans reporting for all three years improved their rates significantly. No plan experienced a decrease. The Maryland HMO/POS average increased seven percentage points over this period. However, analysis of the results for this measure indicates that the consolidation of Aetna plans contributed significantly to the change in the Maryland HMO/POS average from 2000 to 2002. **Changes in the Maryland HMO/POS average should not be interpreted to arise solely from changes in plan performance**. See the Methodology section for further discussion.

In 2002, four plans were above average and five plans were below average. Rates ranged more widely than for the 12-24 month age group, going from 84% to 97% (see Table 36).

Age 7 through 11 Years

From 2000 to 2002, four of the eight plans reporting for all three years significantly improved their rates. No plan experienced a decrease. The Maryland HMO/POS average increased seven percentage points over this period. However, analysis of the results for this measure indicates that the consolidation of Aetna plans contributed significantly to the change in the Maryland HMO/POS average from 2000 to 2002. **Changes in the Maryland HMO/POS average should not be interpreted to arise solely from changes in plan performance**. See the Methodology section for further discussion

In 2002, four plans received above average scores and four plans were below average. Rates ranged from 82% to 95% (see Table 37).

Table 35

Children's Access to Primary Care Providers, 12-24 Months, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**92%**	**96%**	**97%**	**5%**			
Aetna US	--	93%	96%	--	--	○	○
BlueChoice	93%	94%	95%	⇔	⊙	○	○
CIGNA	93%	93%	94%	↑	⊙	○	○
Coventry	97%	96%	97%	⇔	●	⊙	⊙
Delmarva	95%	97%	99%	↑	●	⊙	●
Kaiser	96%	99%	99%	↑	●	●	●
M.D. IPA	97%	96%	98%	⇔	●	⊙	⊙
OCI	96%	97%	97%	↑	●	●	⊙
PHN	90%	97%	98%	↑	⊙	⊙	⊙

Legend:

Change 2000 – 2002

↑ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002"indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Plans cannot be designated as Star Performers for Children's Access to Care measures.

Table 36

Children's Access to Primary Care Providers, 25 Months-6 Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**82%**	**87%**	**89%**	**7%**			
Aetna	--	77%	84%	--	--	○	○
BlueChoice	85%	85%	88%	↑	●	○	○
CIGNA	82%	83%	85%	↑	⊙	○	○
Coventry	91%	90%	92%	⇔	●	●	●
Delmarva	89%	92%	91%	⇔	●	●	●
Kaiser	90%	94%	97%	↑	●	●	●
M.D. IPA	86%	87%	87%	↑	●	⊙	○
OCI	85%	85%	87%	↑	●	○	○
PHN	85%	89%	91%	↑	●	●	●

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002"indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Plans cannot be designated as Star Performers for Children's Access to Care measures.

Table 37

Children's Access to Primary Care Providers, 7-11 Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**82%**	**88%**	**89%**	**7%**			
Aetna	--	81%	82%	--	--	○	○
BlueChoice	85%	85%	88%	↑	●	○	⊙
CIGNA	81%	83%	83%	↑	○	○	○
Coventry	92%	92%	92%	⇔	●	●	●
Delmarva	91%	91%	93%	⇔	●	●	●
Kaiser	91%	97%	95%	↑	●	●	●
M.D. IPA	86%	87%	87%	⇔	●	○	○
OCI	85%	85%	86%	⇔	●	○	○
PHN	87%	90%	92%	↑	●	●	●

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002"indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Plans cannot be designated as Star Performers for Children's Access to Care measures.

Table 38

Children's Access to Primary Care Providers, All Measures, 2002 Results						
	12-24 Months		25 Months-6 Years		7-11 Years	
Maryland HMO/POS Average	**97%**		**89%**		**89%**	
Aetna	96%	○	84%	○	82%	○
BlueChoice	95%	○	88%	○	88%	⊙
CIGNA	94%	○	85%	○	83%	○
Coventry	97%	⊙	92%	●	92%	●
Delmarva	99%	●	91%	●	93%	●
Kaiser	99%	●	97%	●	95%	●
M.D. IPA	98%	⊙	87%	○	87%	○
OCI	97%	⊙	87%	○	86%	○
PHN	98%	⊙	91%	●	92%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Plans cannot be designated as Star Performers for Children's Access to Care measures.

C. PRENATAL AND POSTPARTUM CARE

Background

Prenatal Care

Health plans that provide timely, thorough, and effective prenatal care can help reduce a woman's likelihood of having complications during pregnancy and poor health outcomes for the baby, such as infant mortality and low birth weight. According to the American Medical Association, babies born to mothers who did not receive adequate prenatal care are 44 times more likely to die before their first birthday. Early prenatal care is also an essential part of helping a woman prepare to be a mother. Regular prenatal visits help health care providers prevent, identify, and treat problems. Problems are often corrected easily when discovered early, but when left untreated they can threaten the health of both mother and child.

Despite the benefits of early prenatal care, many pregnant women do not seek prenatal care during their pregnancies. Demographic, economic, and cultural factors influence the decision to seek early prenatal care. HMOs are trying innovative programs to encourage women to seek care. In 1998, the last year these data were updated, the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, reported that 83 percent of pregnant women received prenatal care in the first trimester of pregnancy. The *Healthy People 2010* objective is to increase to 90 percent the proportion of pregnant women receiving prenatal care during the first trimester of pregnancy.

Postpartum Care

The six weeks after giving birth are a period of physical, emotional, and social change when new mothers are adjusting to caring for a new baby. The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once soon after giving birth so that the new mother can be evaluated and receive any necessary assistance. The first postpartum visit includes a physical examination and also provides an opportunity for the health care provider to answer parents' questions, to give family planning guidance, and to offer counseling on nutrition.

Definition of Measure

This measure includes two rates based on the population of commercially insured women who delivered a live birth between November 6, 2000 and November 5, 2001 and who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery. For this (denominator) population, the measure calculates:

Prenatal Care

The percent of women in the denominator who received a prenatal care visit in the first trimester **or** within 42 day of enrollment in the health plan.

Postpartum Care

The percent of women in the denominator who should have had a postpartum visit on or between 21 days and 56 days after delivery and whose medical records indicate that they did have at least one visit.

Notes

The Prenatal and Postpartum Care measure was a new measure in 2001. It replaced both the Check-Ups After Delivery (or Check-Ups for New Moms as the measure is called in the *Consumer Guide*) and Prenatal Care in the First Trimester measures that were part of the HEDIS 2000 measurement set. Changes in the specifications for the Prenatal measure, preclude trending 2001 information against previous years.

Specifically, in 2000, the numerator criterion was a prenatal visit during the first trimester. In 2001, criterion was either a visit during the first trimester **or** a visit within 42 days of joining the plan, if the patient wasn't continuously enrolled during the first trimester. The result is that in 2001, the patient could satisfy the prenatal care criterion with a visit as late as the second or third trimester. Trending is not possible because of these differences.

For the Postpartum measure, like 2000 and 2001, the numerator time frame is 21-56 days after delivery, and the patient has to be continuously enrolled from birth through 56 days post-delivery, so trending is appropriate.

Therefore, plans can achieve Star Performer status for the Postpartum measure but not for the Prenatal measure.

Several factors complicate calculating both the Prenatal and Postpartum Care measures and can influence results. When interpreting results readers should consider the following:

- Demographic, socioeconomic, and cultural factors affect the likelihood of seeking early prenatal care. Demographic and economic profiles of members may be very different among health plans.
- Poor quality coding of maternity data commonly found throughout the industry can complicate accurate measurement by creating difficulties in identifying the true number of live births.
- The majority of HMOs use global billing practices. HMOs pay providers a fixed rate for all maternity services from prenatal to postpartum care, including delivery. This payment can make identifying the number and dates of service of the prenatal care visits difficult.

Results

Prenatal Measure

In 2002, two plans received average scores, five plans were above average, and two plans were below average (see Table 40). Rates ranged from 57% to 92%. This means that in the plan that had the rate of 57%, in 43% of births to its members, no prenatal care was provided in the first trimester of pregnancy (or within seven weeks of joining the plan, if the woman was pregnant when she became a member).

Due to specifications changes, 2001 data cannot be trended against previous years.

Postpartum Measure

From 2000 to 2002, only one of the eight plans reporting for all three years improved its rates significantly. However, no plan experienced a decrease (see Table 39). The Maryland HMO/POS average increased five percentage points over this period. In 2002, five plans received average scores, two plans were above average, and two plans were below average. Rates ranged from 60% to 84%. One plan achieved Star Performer status for this measure.

Comparison of the Prenatal and Postpartum rates (see Table 40) shows that, across Maryland HMOs, more women received appropriate prenatal care (85%) than received any postpartum care (78%), as reported in the HEDIS measures. On average, 22 percent of women did not receive a minimum level of post delivery care.

Table 39

Prenatal and Postpartum Care, Postpartum, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**73%**	**76%**	**78%**	**5%**			
Aetna	--	84%	84%	--	--	●	●
BlueChoice	73%	77%	77%	⇔	⊙	⊙	⊙
CIGNA	78%	79%	81%	⇔	●	⊙	⊙
Coventry	71%	73%	73%	⇔	⊙	⊙	○
Delmarva	79%	77%	82%	⇔	⊙	⊙	⊙
Kaiser	81%	79%	81%	⇔	●	⊙	⊙
*M.D. IPA	80%	82%	82%	⇔	●	●	●
OCI	73%	76%	81%	↑	⊙	⊙	⊙
PHN	61%	61%	60%	⇔	○	○	○

Legend:

Change 2000 – 2002

↑ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002"indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- *Star Performer: This designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001 and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 40

Prenatal and Postpartum Care, 2002 Results				
	Prenatal		Postpartum	
Maryland HMO/POS Average	**85%**		**78%**	
Aetna[r]	92%	●	84%	●
BlueChoice	89%	●	77%	⊙
CIGNA	91%	●	81%	⊙
Coventry[r]	80%	○	73%	○
Delmarva	92%	●	82%	⊙
Kaiser	89%	●	81%	⊙
M.D. IPA	88%	⊙	82%	●
OCI	87%	⊙	81%	⊙
PHN	57%	○	60%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- [r] This measure was eligible for rotation in 2002, and these plans elected to re-submit 2001 data in 2002. All other plans submitted new data.

SATISFACTION WITH THE EXPERIENCE OF CARE

V. SATISFACTION WITH THE EXPERIENCE OF CARE

Summary

This section presents selected results from the CAHPS® 2.0H survey of HMO/POS members included in the samples drawn for plans as detailed in the Introduction section. Kaiser's POS enrollees were not included in either the survey or the audit. Responses for that plan represent HMO enrollees only. For consumers making enrollment decisions, knowledge of current members' opinions of and level of satisfaction with their health plans provides valuable information. Prior to member surveys, consumers relied solely on anecdotal evidence from family, friends, and colleagues. Survey results allow prospective members to assess how well current members believe their plans are meeting their needs. Survey data were collected in April and May 2002.

MHCC contracted with Market Facts, Inc. to conduct the CAHPS® 2.0H survey. As an NCQA-certified survey vendor, Market Facts administered the survey according to protocols established by NCQA. A random sample of 950 members of each health plan was contacted for participation in the mail survey, with phone follow-up for non-respondents.

The survey samples for each plan consisted of current health plan members age 18 and older who were enrolled in the HMO or POS products throughout 2001. This section presents survey results that data analysis has shown to be associated most significantly and meaningfully with overall satisfaction.

Each measure in this section is either based on a single survey question or on the combination of several questions to create a composite measure. Composite measures are groupings of several questions that rate similar aspects of health care or health plan services and have the same response options (for instance: *Never/sometimes/usually/always* versus *a big problem/a small problem/not a problem*).

In this section, both trending tables and 2002 results tables are included for each measure if relevant. The 2002 Results tables indicate the breakdown of responses across all possible response categories (see Table 41).

The following survey measures are included in this section:

Measure	Description
How Members Rated Their Health Plan	Rating of the health plan by respondents using a scale from 0-10 with 0 being the worst and 10 being the best. The percent of members who responded 0-6, 7-8, or 9-10. Comparison is of percent responding 9 or10.
Recommending Plan to Friends/Family	The percent of respondents who would recommend their health plan to friends or family. Comparison is of percent responding definitely yes.
Few Consumer Complaints	The percent of respondents who called or wrote their health plan with a complaint or problem. Comparison is of percent that did not report a problem.
Helpfulness of Information Provided by Plan	Composite measure of three questions regarding whether respondents always, usually, sometimes, or never received information supplied by the plan that was useful. Comparison is of percent responding always.
Health Plan Customer Service	Composite measure of three questions regarding whether it was a big problem, a small problem, or not a problem to get information they needed in written materials from the health plan, to get help from customer service, and with paperwork for the health plan. Comparison is of percent responding not a problem.
Getting Needed Care	Composite measure of four questions regarding whether it was a big problem, a small problem, or not a problem to find a personal doctor or nurse, get a referral to a specialist, get necessary care, and get care approved by the health plan without delays. Comparison is of percent responding not a problem.
Getting Care Quickly	Composite measure of four questions regarding whether respondents always, usually, sometimes, or never received help over the phone, got an appointment for routine or regular care, got an appointment for treatment for illness, and saw their provider during an appointment in a timely manner. Comparison is of percent responding always
How Often Doctors Communicated Well	Composite measure of four questions regarding whether providers always, usually, sometimes, or never listened to respondents carefully; explained things in a way they could understand; showed respect for what they had to say; and spent enough time with them. Comparison is of percent responding always.
Rating of Health Care Received	Rating of the health care received by respondents using a scale from 0-10 with 0 being the worst and 10 being the best. The percent of members who responded 0-6, 7-8, or 9-10. Comparison is of percent responding 9 or 10.

Survey data are not included in the independent audit of the HEDIS measures. However, the audit process does ensure that the population files sent to the survey administrator are not significantly biased and meet the technical specifications established by NCQA. These files were used by the survey vendor to draw the random survey samples representing the members of each health plan.

Overall CAHPS® 2.0H Survey Results

Table 41 provides a summary of the 2002 rates for all nine CAHPS® measures reported here.

As directed by NCQA, calculation of response rates for the survey measures has changed for reporting year 2002. In prior years members having "a missing or undeliverable address and a missing or invalid phone number" received a disposition of ineligible. Ineligible respondents are subtracted from the total sample. By removing those members from the total sample, the denominator decreased, thereby, increasing final response rates slightly. Now, members assigned this disposition are classified as Non-respondents and remain in the denominator (total sample) in the response rate formula.

In general, increases in CAHPS® rates were substantially less than the increases in HEDIS rates over the 2000 to 2002 period. This may be due, in part, to the ability of plans to improve HEDIS rates by increasing data completeness and improving rate calculation processes. By comparison, the survey questions and methodology are less prone to data quality/completeness issues and, therefore, rate changes are unlikely to be a result of amelioration of such data issues.

Six of the seven CAHPS® measures for which trending information is available experienced increases of three percentage points or less from 2000 to 2002. Most improvement over 2000 was seen in the percent of respondents who said they had not complained. That measure improved by eight percentage points, from 75% in 2000 to 83% in 2002. For two of the six CAHPS® measures*, Getting Care Quickly and How Often Doctors Communicated Well,* rates declined from 2000.

Table 41

Satisfaction with the Experience of Care, 2002 Results									
	How Members Rate Their Health Plan[a]	Recommending Plan to Friends/Family[b]	Few Consumer Complaints[c]	Helpfulness of Information Provided by Plan[d]	Health Plan Customer Service[e]	Getting Needed Care[e]	Getting Care Quickly[f]	How Often Doctors Communicated Well[f]	Rating Health Care Received[g]
Maryland HMO/POS Average	**37%**	**34%**	**83%**	**30%**	**68%**	**77%**	**42%**	**56%**	**46%**
Aetna	○	○	⊙	⊙	⊙	⊙	⊙	⊙	⊙
BlueChoice	○	⊙	○	○	○	○	⊙	○	⊙
CIGNA	○	○	⊙	⊙	⊙	○	○	⊙	○
Coventry	●	⊙	○	⊙	⊙	●	⊙	⊙	●
Delmarva	●	●	●	⊙	●	●	●	●	●
Kaiser	⊙	●	●	●	●	⊙	⊙	○	○
M.D. IPA	⊙	●	⊙	●	●	⊙	●	⊙	⊙
OCI	⊙	⊙	●	⊙	⊙	⊙	⊙	⊙	⊙
PHN	○	○	⊙	○	○	⊙	⊙	⊙	⊙

a. Comparisons based on the percent of members surveyed who gave their health plan a rating of 9 or 10 on a scale of 0-10 with 10 being the best.

b. Comparisons based on the percent of members surveyed who responded "definitely yes" when asked if they would recommend their health plan to friends or family.

c. Comparisons based on the percent of members surveyed who said they "**did not** report" a complaint or problem with their health plan.

d. Comparisons based on the percent of members surveyed who responded "always" to several related questions about how often information from their plan was helpful.

e. Comparisons based on the percent of members surveyed who responded "not a problem" to several related questions.

f. Comparisons based on the percent of members surveyed who responded "always" to several related questions.

g. Comparison based on the percent of members surveyed who gave the health care they received a rating of 9 or 10 on a scale of 0-10 with 10 being the best.

A. HOW MEMBERS RATE THEIR HEALTH PLAN

Definition of Measure

The survey question asked the following:
"Use any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best plan possible. How would you rate your health plan now?"

Results

Relative rates and comparisons are based on the percent of members surveyed who gave their health plan a rating of 9 or 10 on a scale of 0-10 with 10 being the best.

From 2000 to 2002, only one of the eight plans reporting for all three years improved its rate significantly (see Table 42). The Maryland HMO average increased two percentage points (to 37%) over this period. This means, on average, a little more than a third of respondents rated their plan a 9 or 10. One plan is a Star Performer.

In 2002, three plans received average scores, two plans were above average, and four plans were below average. Rates ranged from 29% to 52% (see Table 43).

Table 42

How Members Rate Their Health Plan, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**35%**	**35%**	**37%**	**2%**			
Aetna	--	27%	33%		--	○	○
BlueChoice	35%	36%	31%	⇔	⊙	⊙	○
CIGNA	29%	29%	29%	⇔	○	○	○
Coventry	41%	39%	48%	↑	●	⊙	●
*Delmarva	47%	46%	52%	⇔	●	●	●
Kaiser	38%	36%	34%	⇔	⊙	⊙	⊙
M.D. IPA	42%	43%	41%	⇔	●	●	⊙
OCI	37%	37%	38%	⇔	⊙	⊙	⊙
PHN	32%	28%	29%	⇔	⊙	○	○

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who gave their health plan a rating of 9 or 10 on a scale of 0-10 with 10 being the best.
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 43

How Members Rate Their Health Plan, 2002 Results				
	Rating 0-6	Rating 7-8	Rating 9-10	2002 Category
Maryland HMO/POS Average	**22%**	**40%**	**37%**	
Aetna	28%	40%	33%	○
BlueChoice	26%	42%	31%	○
CIGNA	28%	42%	29%	○
Coventry	17%	35%	48%	●
Delmarva	12%	36%	52%	●
Kaiser	21%	45%	34%	⊙
M.D. IPA	18%	41%	41%	⊙
OCI	24%	39%	38%	⊙
PHN	28%	43%	29%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who gave their health plan a rating of 9 or 10 on a scale of 0-10 with 10 being the best.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

B. RECOMMENDING PLAN TO FRIENDS/FAMILY

Definition of Measure

The survey question asked the following:

- *"Would you recommend your health plan to friends or family?"*

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "definitely yes" when asked if they would recommend their health plan to friends or family.

Because the measure was new in 2001, trending information is not available and plans cannot achieve Star Performer status.

In 2002, three plans reporting received average scores, three plans were above average, and three plans were below average (see Table 44). Rates ranged widely from 27% to 45%. All plans had rates reflecting that fewer than half of respondents would recommend their plan without qualification. On average, a third of members said they would definitely recommend their plan.

Table 44

Recommending Plan to Friends/Family, Trending				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2001	2002	2001	2002
Maryland HMO/POS Average	**34%**	**34%**		
Aetna	30%	27%	○	○
BlueChoice	37%	30%	⊙	⊙
CIGNA	27%	29%	○	○
Coventry	36%	39%	⊙	⊙
Delmarva	45%	40%	●	●
Kaiser	43%	40%	●	●
M.D. IPA	42%	45%	●	●
OCI	30%	30%	○	⊙
PHN	22%	28%	○	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "definitely yes" when asked if they would recommend their health plan to friends or family.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

Table 45

Recommending Plan to Friends/Family, 2002 Results					
	Definitely Not	Probably Not	Probably Yes	Definitely Yes	2002 Category
Maryland HMO/POS Average	**4%**	**10%**	**52%**	**34%**	
Aetna	5%	14%	53%	27%	○
BlueChoice	4%	10%	55%	30%	⊙
CIGNA	6%	13%	52%	29%	○
Coventry	2%	7%	52%	39%	⊙
Delmarva	3%	7%	51%	40%	●
Kaiser	4%	10%	46%	40%	●
M.D. IPA	2%	7%	46%	45%	●
OCI	3%	10%	57%	30%	⊙
PHN	4%	12%	55%	28%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "definitely yes" when asked if they would recommend their health plan to friends or family.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

C. FEW CONSUMER COMPLAINTS

Definition of Measure

The survey question asked the following:

- *"In the last 12 months, have you called or written your health plan with a complaint or problem?"*

Results

Relative rates and comparisons are based on the percent of members surveyed who said they did not report a complaint or problem with their health plan. Higher rates mean fewer members complained.

From 2000 to 2002, three of the eight plans reporting for all three years improved their rates significantly (see Table 46). The Maryland HMO/POS average (at 83% in 2002) increased eight percentage points over this period. On average, 17% of respondents said they had formally complained about their plan during the previous year, three plans are Star Performers.

In 2002, four plans received average scores, three plans were above average, and two plans were below average (see Table 47). Rates ranged from 77% to 89%.

Table 46

Few Consumer Complaints, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**75%**	**78%**	**83%**	**8%**			
Aetna	--	72%	81%		--	○	⊙
BlueChoice	83%	77%	77%	🡻	●	⊙	○
CIGNA	77%	78%	82%	⇔	⊙	⊙	⊙
Coventry	77%	72%	77%	⇔	⊙	○	○
*Delmarva	84%	83%	89%	🡹	●	●	●
*Kaiser	89%	87%	88%	⇔	●	●	●
M.D. IPA	80%	80%	83%	⇔	●	⊙	⊙
*OCI	78%	84%	86%	🡹	●	●	●
PHN	64%	71%	82%	🡹	○	○	⊙

Legend:

Change 2000 – 2002

- 🡹 Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- 🡻 Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who said they did not report a complaint or problem with their health plan.
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 47

Few Consumer Complaints, 2002 Results			
	No, Did not Complain	Yes, Did Complain	2002 Category
Maryland HMO/POS Average	**83%**	**17%**	
Aetna	81%	19%	⊙
BlueChoice	77%	23%	○
CIGNA	82%	18%	⊙
Coventry	77%	23%	○
Delmarva	89%	11%	●
Kaiser	88%	12%	●
M.D. IPA	83%	17%	⊙
OCI	86%	14%	●
PHN	82%	18%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who said they did not report a complaint or problem with their health plan.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

D. HELPFULNESS OF INFORMATION PROVIDED BY PLAN

Definition of Measure

Composite measure reflecting the percent of members who responded "Always" when asked, "How often were information and materials helpful in:"

- "Explaining referral rules and procedures"
- "Choosing a personal doctor or primary care provider"
- "Explaining what services and test your plan coverage will pay for"

This measure was new in 2001. It replaced the following three measures that were reported in the 2000 Comprehensive Report:

- Helpfulness of Information for Choosing a Physician
- Helpfulness of Information Explaining Referral Rules
- Helpfulness of Coverage Information

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "*always*" to several related questions about how often information from their health plan was useful.

In 2002, five plans received average scores, two plans were above average, and two plans were below average (see Table 48). Rates ranged from 20% to 36%. In 2001, the average rate of members who responded always to these questions was 29%; in 2002, the average rate was 30%.

These three questions are not part of the core CAHPS® 2.0H survey, but are asked of all Maryland respondents. The questions were grouped into a composite and included for the first time in 2001. Therefore, plans cannot achieve Star Performer status for this measure.

Table 48

Helpfulness of Information Provided by Plan, Trending				
	Comparison of Absolute Rates		*Comparison of Relative Rates*	
	2001	2002	2001	2002
Maryland HMO/POS Average	**29%**	**30%**		
Aetna	30%	33%	⊙	⊙
BlueChoice	27%	20%	⊙	○
CIGNA	25%	28%	○	⊙
Coventry	28%	29%	⊙	⊙
Delmarva	35%	32%	●	⊙
Kaiser	30%	34%	⊙	●
M.D. IPA	34%	36%	●	●
OCI	27%	30%	⊙	⊙
PHN	22%	25%	○	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always*" to several related questions about how often information from their health plan was useful.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

Table 49

Helpfulness of Information Provided by Plan, 2002 Results					
	Did Not Receive	**Sometimes/ Never**	**Usually**	**Always**	**2002 Category**
Maryland HMO/POS Average	**16%**	**23%**	**31%**	**30%**	
Aetna	12%	24%	30%	33%	⊙
BlueChoice	23%	28%	29%	20%	○
CIGNA	16%	26%	30%	28%	⊙
Coventry	23%	19%	28%	29%	⊙
Delmarva	16%	20%	31%	32%	⊙
Kaiser	13%	24%	29%	34%	●
M.D. IPA	11%	17%	36%	36%	●
OCI	15%	22%	33%	30%	⊙
PHN	13%	30%	31%	25%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always*" to several related questions about how often information from their health plan was useful.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

E. HEALTH PLAN CUSTOMER SERVICE

Definition of Measure

This composite measure consisted of the following survey questions:

- *"In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?"*

  (Only respondents who looked for information in written materials from the health plan in the last 12 months were asked this question.)

- *"In the last 12 months, how much of a problem, if any, was it to get help you needed when you called your health plan's customer service?"*

  (Only respondents who had to call their health plan's customer service to get information or help in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"*

  (Respondents who had no experiences with paperwork for their health plan in the last 12 months were considered NOT having a problem with paperwork).

Notes

Rates for 2000, 2001 and 2002 are based on current NCQA methodology. According to the NCQA Summary Rate calculation, respondents who had no experience in paperwork automatically answered "Not a Problem" to the question, asked "In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?"

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem*" to the preceding questions.

From 2000 to 2002, one of the eight plans reporting for all three years decreased its rate significantly (see Table 50). The remaining plans neither increased nor decreased their rates significantly. The Maryland HMO/POS average increased two percentage points over this period. Three plans were Star Performers.

In 2002, four plans received average scores, three plans were above average, and two plans were below average (see Table 51). Rates ranged from 57% to 76%.

Table 50

Health Plan Customer Service, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**66%**	**66%**	**68%**	**2%**			
Aetna	--	63%	68%		--	⊙	⊙
BlueChoice	68%	65%	57%	⇩	⊙	⊙	○
CIGNA	67%	65%	66%	⇔	⊙	⊙	⊙
Coventry	67%	65%	66%	⇔	⊙	⊙	⊙
*Delmarva	77%	76%	76%	⇔	●	●	●
*Kaiser	78%	74%	76%	⇔	●	●	●
*M.D. IPA	72%	75%	75%	⇔	●	●	●
OCI	70%	70%	69%	⇔	●	●	⊙
PHN	60%	55%	60%	⇔	○	○	○

Legend:

Change 2000 – 2002

⇧ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
⇩ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem.*"
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 51

Health Plan Customer Service, 2002 Results				
	Big Problem	Small Problem	Not a Problem	2002 Category
Maryland HMO/POS Average	**10%**	**22%**	**68%**	
Aetna	11%	21%	68%	⊙
BlueChoice	15%	28%	57%	○
CIGNA	14%	20%	66%	⊙
Coventry	10%	25%	66%	⊙
Delmarva	5%	19%	76%	●
Kaiser	7%	17%	76%	●
M.D. IPA	6%	19%	75%	●
OCI	7%	24%	69%	⊙
PHN	14%	27%	60%	○

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem.*"
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

F. GETTING NEEDED CARE

Definition of Measure

This measure is a composite of several questions. This composite measure consisted of the following CAHPS® survey questions:

- *"With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?"*

  (Only respondents who got a new personal doctor/nurse when they joined the health plan were asked this question.)

- *"In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?"*

  (Only respondents who thought they needed to see a specialist in the last 12 months were asked this question.)

- *"In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor believed necessary?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem*" to the above questions.

From 2000 to 2002, none of the eight plans reporting for all three years significantly improved its rate (see Table 52). The Maryland HMO/POS average increased two percentage point over this period, Two plans are Star Performers.

In 2002, five plans received average scores, two plans were above, and two plans were below average, (see Table 53). Rates ranged from 73% to 84%.

Table 52

Getting Needed Care, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**75%**	**75%**	**77%**	**2%**			
Aetna	--	71%	77%		--	○	⊙
BlueChoice	75%	74%	73%	⇔	⊙	⊙	○
CIGNA	73%	67%	73%	⇔	⊙	○	○
*Coventry	83%	81%	81%	⇔	●	●	●
*Delmarva	82%	83%	84%	⇔	●	●	●
Kaiser	76%	73%	75%	⇔	⊙	○	⊙
M.D. IPA	77%	80%	79%	⇔	⊙	●	⊙
OCI	78%	76%	75%	⇔	⊙	⊙	⊙
PHN	77%	74%	74%	⇔	⊙	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem.*"
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 53

Getting Needed Care, 2002 Results				
	Big Problem	Small Problem	Not a Problem	2002 Category
Maryland HMO/POS Average	**7%**	**17%**	**77%**	
Aetna	7%	16%	77%	⊙
BlueChoice	7%	20%	73%	○
CIGNA	8%	19%	73%	○
Coventry	6%	13%	81%	●
Delmarva	5%	11%	84%	●
Kaiser	8%	17%	75%	⊙
M.D. IPA	4%	17%	79%	⊙
OCI	5%	19%	75%	⊙
PHN	8%	18%	74%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*not a problem.*"
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

G. GETTING CARE QUICKLY

Definition of Measure

This composite measure consisted of the following survey questions:

- *"In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?"*
  (Only respondents who called a doctor's office during regular office hours to get help or advice for themselves in the last 12 months were asked this question.)
- *"In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?"*
  (Only respondents who made an appointment with a doctor or other health provider for regular or routine health care in the last 12 months were asked this question.)
- *"In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?"*
  (Only respondents who had an illness or injury that needed care right away from a doctor's office, clinic, or emergency room in the last 12 months were asked this question.)
- *"In the last 12 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time to see the person you went to see?"*
  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "*always*" to the above questions.

From 2000 to 2002, none of the eight plans reporting for all three years significantly improved its rate (see Table 54). The Maryland HMO/POS average decreased three percentage point over this period. This is one of two CAHPS® measures for which Maryland rates, on average, declined. One plan was designated a Star Performer for this measure

In 2002, six plans received average scores, two plans were above average, and one plan was below average (see Table 55). Rates ranged from 37% to 50%.

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Table 54

Getting Care Quickly, 2002 Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**45%**	**44%**	**42%**	**-3%**			
Aetna	--	42%	40%		--	⊙	⊙
BlueChoice	43%	44%	39%	⇔	⊙	⊙	⊙
CIGNA	44%	41%	37%	⇔	⊙	○	○
Coventry	48%	51%	45%	⇔	⊙	●	⊙
*Delmarva	51%	49%	50%	⇔	●	●	●
Kaiser	45%	43%	41%	⇔	⊙	⊙	⊙
M.D. IPA	47%	45%	47%	⇔	⊙	⊙	●
OCI	47%	41%	41%	⇔	⊙	⊙	⊙
PHN	49%	41%	42%	⇔	●	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always.*"
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 55

Getting Care Quickly, 2002 Results				
	Sometimes/ Never	Usually	Always	2002 Category
Maryland HMO/POS Average	**22%**	**36%**	**42%**	
Aetna	25%	35%	40%	⊙
BlueChoice	26%	35%	39%	⊙
CIGNA	25%	38%	37%	○
Coventry	19%	37%	45%	⊙
Delmarva	18%	32%	50%	●
Kaiser	23%	36%	41%	⊙
M.D. IPA	20%	33%	47%	●
OCI	22%	37%	41%	⊙
PHN	21%	37%	42%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always.*"
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

H. HOW OFTEN DOCTORS COMMUNICATED WELL

Definition of Measure

This composite measure consisted of the following survey questions:

- *"In the last 12 months, how often did doctors or other health providers listen carefully to you?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how often did doctors or other health providers show respect for what you had to say?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

- *"In the last 12 months, how often did doctors or other health providers spend enough time with you?"*

  (Only respondents who had been to a doctor's office or clinic in the last 12 months to get care for themselves were asked this question.)

Results

Relative rates and comparisons are based on the percent of members surveyed who responded "*always*" to the above questions.

From 2000 to 2002, none of the eight plans reporting for all three years improved its rate significantly (see Table 56). The Maryland average, of 56% in 2002, decreased two percentage points over this period. One plan was designated a Star Performer.

In 2002, six plans received average scores, one plan was above average, and two plans were below average (see Table 57). Rates ranged from 50% to 66%.

Table 56

How Often Doctors Communicated Well, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**58%**	**58%**	**56%**	**-2%**			
Aetna	--	55%	57%		--	⊙	⊙
BlueChoice	56%	56%	52%	⇔	⊙	⊙	○
CIGNA	57%	54%	53%	⇔	⊙	○	⊙
Coventry	59%	61%	58%	⇔	⊙	⊙	⊙
*Delmarva	62%	63%	66%	⇔	●	●	●
Kaiser	50%	52%	50%	⇔	○	○	○
M.D. IPA	60%	59%	59%	⇔	⊙	⊙	⊙
OCI	57%	56%	53%	⇔	⊙	⊙	⊙
PHN	65%	59%	58%	⇔	●	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always.*"
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 57

How Often Doctors Communicated Well, 2002 Results				
	Sometimes/ Never	Usually	Always	2002 Category
Maryland HMO/POS Average	**11%**	**33%**	**56%**	
Aetna	11%	32%	57%	⊙
BlueChoice	12%	36%	52%	○
CIGNA	11%	36%	53%	⊙
Coventry	8%	34%	58%	⊙
Delmarva	7%	28%	66%	●
Kaiser	16%	34%	50%	○
M.D. IPA	9%	32%	59%	⊙
OCI	13%	34%	53%	⊙
PHN	10%	32%	58%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who responded "*always.*"
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

I. RATING OF HEALTH CARE RECEIVED

Definition of Measure

The survey question asked the following:

"Use any number from 0 to 10 where 0 is the worst health care possible, and 10 is the best care possible. How would you rate all your health care?"

Results

Relative rates and comparisons are based on the percent of members surveyed who gave their health care a *rating of 9 or 10* on a scale of 0-10 with 10 being the best.

From 2000-2002, none of the eight plans reporting for all three years improved its rate significantly (see Table 58). The Maryland HMO/POS average increased three percentage points over this period. Two plans are Star Performers.

In 2002, five plans received average scores, two plans were above average and two plans were below average (see Table 59). Rates ranged from 38% to 56%. On average, in 2002, 46% of respondents said they would rate the health care they receive as 9 or 10 on a 10-point scale.

Table 58

Rating Health Care Received, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**43%**	**44%**	**46%**	**3%**			
Aetna	--	39%	46%		--	○	⊙
BlueChoice	40%	45%	45%	⇔	⊙	⊙	⊙
CIGNA	41%	38%	39%	⇔	⊙	○	○
*Coventry	50%	50%	54%	⇔	●	●	●
*Delmarva	52%	52%	56%	⇔	●	●	●
Kaiser	40%	38%	38%	⇔	⊙	○	○
M.D. IPA	49%	50%	48%	⇔	●	●	⊙
OCI	45%	44%	45%	⇔	⊙	⊙	⊙
PHN	50%	43%	44%	⇔	●	⊙	⊙

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who gave their health care a *rating of 9 or 10* on a scale of 0-10 with 10 being the best.
- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

Table 59

Rating Health Care Received, 2002 Results				
	Rating 0-6	Rating 7-8	Rating 9-10	2002 Category
Maryland HMO/POS Average	**15%**	**39%**	**46%**	
Aetna	18%	36%	46%	⊙
BlueChoice	16%	39%	45%	⊙
CIGNA	14%	47%	39%	○
Coventry	11%	35%	54%	●
Delmarva	10%	34%	56%	●
Kaiser	20%	42%	38%	○
M.D. IPA	12%	40%	48%	⊙
OCI	15%	41%	45%	⊙
PHN	15%	41%	44%	⊙

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates and comparisons are based on the percent of members surveyed who gave their health care a *rating of 9 or 10* on a scale of 0-10 with 10 being the best.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Results do not include ineligible respondents.
- Numbers may not add to 100% due to rounding.

HEALTH PLAN STABILITY

VI. HEALTH PLAN STABILITY

Summary

This section presents results for the HEDIS Health Plan Stability measure that MHCC requires Maryland HMOs to report in 2002. Stability is important to consider when reviewing other aspects of health plan performance since past performance can be a good predictor of future performance, assuming a plan's structure and health care delivery systems are reasonably stable.

In 2002, commercial plans in Maryland reported Practitioner Turnover only.

Measure	Description
Practitioner Turnover	The percent of primary care providers who left the plan during the reporting year.

A. PRACTITIONER TURNOVER

Background

The percentage of providers who leave a health plan may have implications for the quality of health care members receive. Although there is little evidence that high turnover has an impact on the quality of care for acute illnesses, several studies have shown that continuity of providers in treating chronic illnesses is desirable. In addition, most patients prefer to establish an on-going relationship and, thereby, increase their level of comfort with their physician. Some provider turnover is normal and expected due to individual changes in circumstances such as relocation or retirement. High rates of provider departure, however, may be a sign of providers' dissatisfaction with the health plan. Conversely, plans may end contracts with providers who are not adhering to the plans' administrative or health care standards.

Definition of Measure

This measure shows two percentages: one for primary care physicians (PCPs) and one for non-physician primary care practitioners affiliated with the health plan at the end of 2000 who were not affiliated with the health plan at the end of 2001.

Notes

For this measure, lower rates indicate better performance. Therefore, above average performance is based on achieving lower than average provider turnover rates.

This measure is affected by health plan mergers, acquisitions, and other marketplace changes. Any health plan that has undergone a recent organizational change is likely to have a higher than usual turnover rate. The higher rate is usually an adjustment to change and tends to stabilize in subsequent years.

Results

This measure is not reported in the *Consumer Guide*, therefore, plans cannot achieve Star Performer status.

From 2000 to 2002, the practitioner turnover rate has continued to decrease across Maryland HMOs and POS plans, dropping three percentage points (see Table 60). Additionally, four of the eight plans reporting for all three years experienced significant decreases in their practitioner turnover rate, indicating greater stability.

In 2002, the Maryland HMO/POS average for the PCP turnover rate was eight percent. Five plans reported lower than average turnover rates. Two plans received an average score, two plans were above average, and two plans were below average. Rates ranged from 3% to 11%.

Table 60

Practioner Turnover PCP, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**11%**	**10%**	**8%**	**-3%**			
Aetna	--	12%	8%	--	--	○	⊙
BlueChoice	2%	1%	3%	⇔	●	●	●
CIGNA	7%	8%	7%	⇔	●	●	⊙
Coventry	17%	11%	7%	🡻	○	○	●
Delmarva	5%	10%	9%	⇔	●	⊙	⊙
Kaiser	21%	13%	11%	🡻	○	○	○
M.D. IPA	10%	11%	9%	🡻	⊙	○	⊙
OCI	12%	13%	9%	🡻	⊙	○	○
PHN	7%	8%	8%	⇔	●	●	⊙

Legend:

Change 2000 - 2002

- 🡹 Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- 🡻 Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ❍ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Since a higher rate is worse for this measure, the above/below average categories have been reversed , i.e., a lower than average turnover rate is indicated by a "filled circle".

USE OF SERVICES

VII. USE OF SERVICES

Summary

This section presents results for the HEDIS Use of Services measures that MHCC required Maryland HMOs to report in 2002. Monitoring utilization is essential for any managed care organization and the Use of Services rates included in this section can be valuable for comparison and analytical purposes.

The Use of Services measures are collected as a way of identifying overutilization and underutilization. Since no "appropriate" amount of these services has ever been determined, their value is in determining normal distribution of services among various plans. When a plan's rate for a measure is much higher (or lower) than the rates of other plans, it should serve as an indicator that further analysis is warranted to determine what could be contributing to the disparate use rates. Although a gold standard does not exist for utilization measures, identifying outlier rates will indicate that something different is occurring with the plan, its providers, or its members.

The concept behind collecting these data is that once identified, HMOs can target areas for further study or improvement. Results for measures in this domain are affected by many member characteristics that can vary greatly among health plans, including age and gender, current medical condition, socioeconomic status, and race. There are two different types of measures in this domain:

- Use of Services measures that report the percent of members who received certain services are similar in structure to the Effectiveness of Care measures. These measures report information on a subset of members who were continuously enrolled in the health plan for a specified period of time. The measures impacted by these enrollment requirements are Well-Child Visits in the First 15 Months of Life, Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life, and Adolescent Well-Care Visits. Plans may collect information for these measures from medical records using the hybrid reporting methodology. ***For these measures, a higher rate indicates better performance.***

- Rates of utilization, which are often expressed as rates of service used per 1,000 member months or may be converted to rates of services used per year. Unlike Effectiveness of Care and Access/Availability of Care measures, continuous enrollment criteria do not factor into most of these rate calculations. The number of member months is the sum of the number of months each member is enrolled in the plan each year. For plans with stable memberships, the reported number of member years is close to the number of members enrolled at any point in time during the year. This comparison may not apply to plans with growing or declining enrollment. *For these measures, rates are not correlated with performance.*

This domain includes the following measures collected in Maryland:

Measure	Description
Well-Child Visits in the First 15 Months of Life	The percent of children who had six or more well-child visits by the time they turned 15 months of age.
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	The percent of children age 3-6 who received one or more well-child visits with a primary care physician during the past year.
Well-Child Visits for Infants and Children (Composite)	This measure combines rates well child visits for infants age 15 months and well child visits for children age three to six to create one composite measure. Criteria remain the same as in the individual measures.
Adolescent Well-Care Visits	The percent of plan members age 12-21 who received at least one well-care visit with a primary care provider during the past year.
Frequency of Selected Procedures	A summary of the rate of several frequently performed procedures.
Discharges and Average Length of Stay – Maternity Care	An estimate of discharges and average length of stay for members with maternity hospitalizations (Total, Vaginal and Cesarean Section Deliveries).
Cesarean Section (C-Section) Rate	The percent of women who delivered by Cesarean section.
Vaginal Birth After Cesarean (VBAC) Rate	The percent of women who delivered vaginally after having a previous Cesarean Section.
Drug Utilization (Outpatient)	A summary of outpatient utilization of prescription drugs, including average cost of prescriptions and average number of prescriptions.

Measures related to behavioral health and use of facilities are included in separate sections of this *Comprehensive Report*.

Factors Affecting the Interpretation of Results

Several factors complicate calculation of the Use of Services measures and can lead to misleading results. When interpreting results, readers should consider the following:

- Utilization is significantly influenced by the characteristics of the member population. HEDIS rates are not risk-adjusted so variation in the results between plans may be affected by real differences in member health, race, education, and socioeconomic status. These differences may be most obvious in rates of utilization for various procedures.
- "Gold standards" or accepted targets for these rates do not exist. High rates could indicate overutilization while low rates could indicate underutilization; neither higher nor lower rates clearly indicate better performance for some of these measures.
- Many of these measures rely on data for the entire population rather than a sample. Therefore, the results are more likely to be affected by data completeness issues.
- Health plan utilization departments do not always measure utilization using the same method as the HEDIS specifications, so health plans do not have comparable internal rates to determine reasonableness of the results.

As a result of the factors listed above, relative rates (i.e., above/below average scores) are not presented for rates of procedures inter-plan comparisons are not appropriate. In addition, given the large number of these measures, only 2002 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for that year.

A. WELL-CHILD AND ADOLESCENT VISIT MEASURES

This section covers the following measures:

- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Well-Child Visits for Infants and Children (Composite)
- Adolescent Well-Care Visits

Background

Well-child visits, or regular check ups, are one of the best ways to detect physical, developmental, behavioral, and emotional problems so that appropriate treatment can be given. Check ups also provide an opportunity for physicians to offer guidance and counseling to parents.

These visits are particularly important during the first year of life, when an infant undergoes substantial changes in abilities, physical growth, motor skills, eye-hand coordination, social, and emotional growth. **The American Academy of Pediatrics (AAP) recommends 6 well-child visits in the first year of life: the first within the first month of life and then at 2, 4, 6, 9, and 12 months.**

Well-child visits during the pre-school and early elementary school years are important to assess the extent to which children are reaching expected milestones, thereby, increasing their chances of achieving their full potential. Through early detection and intervention, vision, speech and language problems can be addressed. **The AAP recommends annual well-child visits for 2 to 6-year olds.**

Finally, an annual preventive health care visit that addresses physical, emotional, and social aspects of health and promotes a healthy lifestyle as well as disease prevention is important for adolescents. Adolescence is a time of transition between childhood and adulthood. During this period, dramatic physical and emotional changes take place. Unintentional injuries, homicide, and suicide are the leading causes of adolescent death. Other health-related issues such as sexually transmitted diseases, substance abuse, pregnancy, and antisocial behavior can cause physical, emotional, and social problems for adolescents. **The American Medical Association Guidelines for Adolescent Preventive Services, the federal government's Bright Futures program, and new AAP guidelines all recommend comprehensive annual check-ups for adolescents.**

Definition of Measure

Well-Child Visits in the First 15 Months of Life

This measure reports the percentage of children, continuously enrolled in the health plan from 31 days of age to 15 months of age who received **six or more** well-child visits by the time they reached 15 months of age.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure reports the percentage of children age 3, 4, 5, and 6, continuously enrolled during 2001 who received **one or more** well-child visits with a primary care physician during the year.

Well-Child Visits for Infants and Children

This measure combines rates well child visits for infants age 15 months and well child visits for children age three to six into create one composite measure. Criteria remain the same as in the individual measures.

Adolescent Well-Care Visits

This measure reports the percentage of plan members age 12-21, continuously enrolled during 2001 who received **at least one** well-care visit with a primary care provider during the year.

Notes

These measures are similar to the Effectiveness of Care measures in that higher rates indicate better performance. That being the case, trending and relative performance information is presented for these measures.

Starting in 2000, MHCC reports a combined measure covering both the Well-Child Visits in the First 15 Months of Life measure and the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life measure, and, therefore plans can de designated Star Performers for the combined Well-Child Visits measure. Plans can also achieve Star Performer status for the Adolescent Well-Care measure.

Several factors complicate calculating these measures and can lead to underreporting. When interpreting results, readers should consider the following:

- Poor quality coding of ambulatory data commonly found in capitated managed care environments could complicate accurate measurement.
- Providers often do not include codes for well-child visits on encounter forms submitted to HMOs, especially when other procedures are performed during the office visit.
- As noted earlier, these measures are extremely susceptible to data completeness issues. Many plans must use the hybrid method to calculate these measures. However, NCQA criteria for identifying a well-child visit in the medical record

are more stringent than for using administrative data. Plans must find evidence of a health and developmental history, both physical and mental; a physical exam; and health education/anticipatory guidance. Due to the level of interpretation allowed by the specifications, many plans have not applied the criteria in a consistent manner.

Results

Analysis of the results for all measures in this section indicates that the consolidation of Aetna plans contributed significantly to the change in the Maryland HMO average from 2000 to 2001 and 2002. **Changes in the Maryland HMO average should not be interpreted to arise solely from changes in plan performance**. See the Methodology section for further discussion.

Comparison of 2002 results across the three measures shows similar rates for the "15 month" and "3-6 year" measures; Maryland HMO averages are 66% and 68%, respectively (Table 61). Well child visits declined significantly for adolescents, with the Maryland HMO average reaching only 37%.

Well-Child Visits in the First 15 Months of Life

From 2000-2002, five of the eight plans reporting for all three years improved their rates significantly (see Table 62). The Maryland HMO average increased eight percent over this period. In 2002, two plans received average scores, five plans were above average, and two plans were below average. Rates ranged widely from 47% to 77%. As discussed in the Notes section, plans cannot achieve Star Performer status for this measure.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

From 2000-2002, three of the eight plans reporting for all three years improved their rates significantly (see Table 63). One plan decreased significantly over the three-year period. The Maryland average increased six percentage points over this period. In 2002, three plans received average scores, three plans were above average, and three plans were below average. Rates ranged from 59% to 76%. As discussed in the Notes section, plans cannot achieve Star Performer status for this measure.

Well-Child Visits for Infants and Children- Composite

From 2000-2002, two of the eight plans reporting for all three years improved their rates significantly (see Table 64). The Maryland average increased seven percentage points over this period. In 2002, one plan received average scores, five plans were above average, and three plans were below average. Rates ranged widely from 54% to 76%. Four plans were Star Performers.

Adolescent Well-Care Visits

From 2000-2002, three of the eight plans reporting for all three years improved their rates significantly. One plan decreased significantly over the three-year period (see Table 65).

The Maryland average increased five percentage points over this period. In 2002, three plans received average scores, two plans were above average, and four plans were below average. Rates ranged widely from 29% to 45%. One plan was a Star Performer.

Table 61

Well-Child/Adolescent Visits, 2002 Results						
	Well-Child Visits in the First 15 Months		Well-Child Visits in the 3rd, 4th, 5th, 6th Years		Adolescent Well-Care Visits	
Maryland HMO/POS Average	**66%**		**68%**		**37%**	
Aetna	47%	○	62%	○	33%	○
BlueChoice	79%	●	73%	●	38%	⊙
CIGNA	67%	⊙	59%	○	29%	○
Coventry	74%	●	68%	⊙	34%	○
Delmarva	48%	○	61%	○	37%	⊙
Kaiser	66%	⊙	67%	⊙	34%	○
M.D. IPA	70%	●	76%	●	42%	●
OCI	70%	●	69%	⊙	40%	⊙
PHN	77%	●	75%	●	45%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

Table 62

Well-Child Visits in the First Fifteen Months, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**58%**	**64%**	**66%**	**8%**			
Aetna	--	42%	47%	--	--	○	○
BlueChoice	84%	81%	79%	⇔	●	●	●
CIGNA	60%	64%	67%	↑	⊙	⊙	⊙
Coventry	73%	73%	74%	⇔	●	●	●
Delmarva	52%	54%	48%	⇔	⊙	○	○
Kaiser	55%	55%	66%	↑	○	○	⊙
M.D. IPA	66%	69%	70%	↑	●	●	●
OCI	66%	66%	70%	↑	●	●	●
PHN	69%	69%	77%	↑	●	●	●

Legend:

Change 2000 - 2002

↑ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Because this measure was combined with another for public reporting, plans cannot be designated as a Star Performer for this measure.

Table 63

Well-Child Visits in the 3rd, 4th, 5th, 6th Years, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**62%**	**68%**	**68%**	**6%**			
Aetna	--	50%	62%	--	--	○	○
BlueChoice	67%	73%	73%	↑	●	●	●
CIGNA	61%	61%	59%	⇔	⊙	○	○
Coventry	67%	67%	68%	⇔	●	⊙	⊙
Delmarva	62%	62%	61%	⇔	⊙	○	○
Kaiser	65%	65%	67%	↑	●	○	⊙
M.D. IPA	78%	77%	76%	⇔	●	●	●
OCI	76%	69%	69%	↓	●	⊙	⊙
PHN	63%	74%	75%	↑	⊙	●	●

Legend:

Change 2000 - 2002

↑ Plan's rate increased significantly from 2000 to 2002
⇔ Plan's rate did not change significantly from 2000 to 2002
↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- Because this measure was combined with another for public reporting, plans cannot be designated as a Star Performer for this measure.

Table 64

Well-Child Composite, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2002-2000	2000	2001	2002
Maryland HMO/POS Average	**60%**	**66%**	**67%**	**7%**			
Aetna	--	46%	54%	--	--	○	○
*BlueChoice	76%	77%	76%	⇔	●	●	●
CIGNA	60%	62%	63%	⇔	⊙	○	○
*Coventry	70%	70%	71%	⇔	●	●	●
Delmarva	57%	58%	55%	⇔	⊙	○	○
Kaiser	60%	60%	67%	↑	⊙	○	⊙
*M.D. IPA	72%	73%	73%	⇔	●	●	●
OCI	71%	68%	69%	⇔	●	⊙	●
*PHN	66%	71%	76%	↑	●	●	●

Legend:

Change 2000 - 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- This measure combines rates well child visits for infants age 15 months and well child visits for children age three to six to create one composite measure. Criteria remain the same as in the individual measures.
- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.

Table 65

Adolescent Well-Care Visits, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**32%**	**37%**	**37%**	**5%**			
Aetna	--	26%	33%	--	--	○	○
BlueChoice	29%	38%	38%	↑	⊙	⊙	⊙
CIGNA	31%	31%	29%	⇔	⊙	○	○
Coventry	33%	33%	34%	⇔	●	○	○
Delmarva	34%	35%	37%	↑	●	⊙	⊙
Kaiser	34%	34%	34%	⇔	●	○	○
*M.D. IPA	47%	53%	42%	⇔	●	●	●
OCI	48%	44%	40%	↓	●	●	⊙
PHN	32%	41%	45%	↑	⊙	⊙	●

Legend:

Change 2000 – 2002

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- * Star Performer – this designation indicates that a plan has reported a better than average relative rate for this measure for the past three reporting years: 2000, 2001, and 2002. Plans must have operated in their current form within Maryland for three years in order to be eligible to receive this designation.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001 and, therefore, is not eligible for Star Performer designation.

B. FREQUENCY OF SELECTED PROCEDURES

Background

This measure reports utilization rates for several, mostly surgical, procedures that are performed frequently and contribute substantially to health care costs. Considerable variation exists in how often these procedures are performed. Rates for these measures are likely to be influenced strongly by the way a health plan manages care as well as by the demographic characteristics of the plan's members. Data for this measure, and all subsequent measures in the Use of Services section, were collected administratively.

Definition of Measure

Utilization rates for the following procedures are included as part of the Frequency of Selected Procedures measure:

Myringotomy—incision of the eardrum to allow the insertion of ventilating tubes; a treatment for chronic ear infections.

Tonsillectomy/Tonsillectomy and Adenoidectomy—surgical removal of the tonsils or tonsils and adenoids.

Non-Obstetric Dilation and Curettage—dilation and surgical cleansing of the surface of the uterus.

Hysterectomy—surgical removal of the uterus.

Cholecystectomy, open—the surgical removal of the gallbladder through an abdominal incision.

Cholecystectomy, closed (laparoscopic)—the surgical removal of the gallbladder with a laparoscope.

Angioplasty—repairing or replacing damaged blood vessels using lasers or tiny inflatable balloons at the end of a catheter that is inserted into the vessels.

Cardiac Catheterization—a procedure used to diagnose the severity and extent of coronary artery disease.

Coronary Artery Bypass Graft—a surgical procedure used to treat coronary heart disease by grafting a portion of a vein from the patient's leg to replace the portion of the coronary artery that is damaged or blocked.

Laminectomy/Diskectomy—surgery for a herniated disk in the spinal column.

Prostatectomy—surgical removal of the prostate gland.

Results

Results are presented in the tables on the following pages. Because it would be impossible to compare the performance of plans if only the numbers of procedures were provided, results appear as rates; the number of times a procedure was performed per 1,000 members of the plan. This makes it possible to compare to each other very large and very small plans. In most cases, rates are displayed by age and gender. That is because those two factors have much to do with health status and the types of health problems for which people seek care.

These rates are included in the *Comprehensive Report* to facilitate comparison and analysis by plans, providers, and other organizations. As noted in the Introduction to this chapter, utilization rates are significantly influenced by the characteristics of the plan's member population and are vulnerable to data completeness issues. The rates are not risk-adjusted so variation in the results between plans may not be attributed to differences in performance. Further, there is no accepted "gold standard" or target for utilization measures. Therefore, relative rates are not calculated and inter-plan comparisons are not made here. In addition, given the large number of these measures, only 2002 rates are presented. Rates for previous years can be found in the *Comprehensive Report* for the year in question.

It would be prudent for consumers to compare their plan's rate for a procedure they are considering, One should check to see if rates are much higher or lower than those of most other plans for the same procedures. In some instances, a large number of procedures is a good sign (possibly indicating expertise which often comes from performing a higher volume of the same procedures). In other cases, very high numbers might be a flag indicating that more procedures than necessary are occurring. A variation in rates among plans could be a reflection of plans' differing membership characteristics, or differing policies. Some plans could have sicker members than other plans. Extremely low numbers for certain procedures might show that the plan members are younger and healthier or it might mean that those procedures are less available. Very high or low numbers, or "outliers," should be a prompt for consumers to ask for more information.

Table 66

Frequency of Selected Procedures, 2002 Results				
	Procedures/1,000 Members			
	MYR 0-4 years M&F	MYR 5-19 years M&F	TA 0-9 years M&F	TA 10-19 years M&F
Maryland HMO/POS Average	**33.1**	**3.3**	**8.3**	**3.3**
Aetna	40.0	4.4	7.0	3.0
BlueChoice	17.6	1.9	6.7	2.3
CIGNA	22.6	2.7	7.8	3.6
Coventry	53.8	3.8	10.4	3.5
Delmarva	43.9	3.9	13.5	2.6
Kaiser	16.6	2.3	4.6	1.7
M.D. IPA	35.8	4.3	8.0	3.9
OCI	40.0	4.4	9.0	4.4
PHN	28.1	2.0	7.8	4.4

Notes: MYR=Myringotomy
TA=Tonsillectomy and/or Tonsillectomy and Adenoidectomy
M&F=Male/Female

Table 67

Frequency of Selected Procedures, 2002 Results						
	Procedures/1,000 Members					
	D&C 15-44 yrs Female	D&C 45-64 yrs Female	HYS-ab 15-44 yrs Female	HYS-ab 45-64 yrs Female	HYS-vag 15-44 yrs Female	HYS-vag 45-64 yrs Female
Maryland HMO/POS Average	**4.4**	**6.5**	**4.4**	**6.8**	**1.9**	**2.1**
Aetna	4.8	6.7	4.8	7.3	1.6	1.9
BlueChoice	5.6	8.2	2.9	6.2	1.1	1.8
CIGNA	3.2	3.6	3.5	5.6	1.8	2.4
Coventry	1.6	2.4	5.0	6.6	2.5	2.8
Delmarva	3.1	6.2	5.5	8.9	2.2	0.3
Kaiser	1.0	1.7	2.5	4.9	0.5	1.1
M.D. IPA	6.8	9.4	4.7	7.7	2.8	2.8
OCI	6.7	8.6	4.9	7.2	2.1	2.6
PHN	7.0	11.3	6.0	7.2	2.8	2.9

Notes: D&C=Dilation & Curettage
HYS-ab=Hysterectomy-abdominal
HYS-vag=Hysterectomy-vaginal

Table 68

Frequency of Selected Procedures, 2002 Results						
	Procedures/1,000 Members					
	Chol-o 30-64 yrs Male	Chol-o 15-44 yrs Female	Chol-o 45-64 yrs Female	Chol-c 30-64 yrs Male	Chol-c 15-44 yrs Female	Chol-c 45-64 yrs Female
Maryland HMO/POS Average	**0.4**	**0.3**	**0.7**	**1.9**	**4.9**	**6.3**
Aetna	0.4	0.4	1.0	1.5	3.8	5.6
BlueChoice	0.5	0.5	0.7	1.6	4.0	5.7
CIGNA	0.4	0.4	0.4	2.1	4.3	5.7
Coventry	0.3	0.1	0.4	1.8	5.6	6.9
Delmarva	0.2	0.4	0.6	2.3	6.8	7.7
Kaiser	0.3	0.3	0.7	0.9	2.4	3.2
M.D. IPA	0.4	0.3	0.7	2.6	5.5	7.7
OCI	0.4	0.3	1.0	2.5	5.7	7.1
PHN	0.3	0.4	0.4	1.6	5.9	7.0

Notes: Chol-o=Cholecystectomy, open
Chol-c=Cholecystectomy, closed (laparoscopic)

Table 69

Frequency of Selected Procedures, 2002 Results			
	Procedures/1,000 Members		
	LD 20-64 yrs Male	LD 20-64 yrs Female	Pros 45-64 yrs Male
Maryland HMO/POS Average	**3.2**	**2.9**	**2.4**
Aetna	3.1	2.8	2.6
BlueChoice	3.1	2.5	3.6
CIGNA	3.4	3.1	3.1
Coventry	2.6	2.2	1.7
Delmarva	4.3	3.7	1.8
Kaiser	2.1	1.8	2.0
M.D. IPA	3.4	2.9	2.7
OCI	3.3	2.9	2.9
PHN	3.5	4.0	1.6

Notes: LD=Laminectomy/Diskectomy
Pros=Prostatectomy

Table 70

Frequency of Selected Procedures, 2002 Results						
	Procedures/1,000 Members					
	Ang 45-64 yrs Male	Ang 45-64 yrs Female	CC 45-64 yrs Male	CC 45-64 yrs Female	CABG 45-64 yrs Male	CABG 45-64 yrs Female
Maryland HMO/POS Average	**6.0**	**1.8**	**13.6**	**7.8**	**3.0**	**0.8**
Aetna	6.1	2.0	13.1	8.1	3.3	1.2
BlueChoice	8.1	2.3	20.2	9.4	3.7	1.2
CIGNA	4.2	1.2	10.5	6.8	2.8	0.7
Coventry	3.8	0.9	7.5	3.7	3.1	0.5
Delmarva	8.1	1.5	23.2	11.9	2.8	0.0
Kaiser	3.2	1.3	6.8	4.0	2.5	0.7
M.D. IPA	6.1	2.7	13.7	8.9	3.9	0.7
OCI	8.2	2.4	13.9	9.8	3.7	0.9
PHN	5.9	1.4	13.1	7.7	1.4	0.9

Notes: Ang=Angioplasty
CC=Cardiac Catheterization
CABG=Coronary Artery Bypass Graft

C. DISCHARGES AND AVERAGE LENGTH OF STAY – MATERNITY CARE

Definition of Measure

This measure reports maternity-related care based upon the rate of live births during 2001 and includes the hospital average length of stay related to those births. Delivery information is broken down into vaginal and cesarean section categories. Rates are per 1,000 female members.

Notes

Length of hospital stay for women after delivery has become an issue for public debate. Concerns about mothers who, prior to discharge, are not properly taught to care for their newborns or are not sufficiently recovered from the birth, as well as infant health problems that appear shortly after discharge, have increased public interest in the issue. Maryland is one of several states that have passed laws mandating minimum length of obstetric stays: two days for vaginal deliveries and four days for Cesarean sections. Women, obviously, may choose to leave earlier.

Although current public perception holds that a discharge 24-hours after delivery is too soon, there is no ideal length of stay after delivery. Plans with relatively short lengths of stays after delivery can have excellent pediatric and maternal follow-up capabilities, perhaps through home care nursing visits, and may have a higher quality of care than a plan that offers longer lengths of stays, but less follow-up care. In addition, plans with long lengths of stay are not necessarily offering more appropriate medical care; they may be responding to legislative mandates or to patient or provider preferences.

The factor that most complicates maternity-related HEDIS measures is the identification of live births. Poor quality coding of maternity data is an industry-wide problem and is the chief culprit complicating accurate measurement for identifying the true number of live births.

Results

Total maternity discharge rates range from 19.1 per 1,000 female members to 30.1 per 1,000 female members (see Table 71). As expected, across all HMOs, the average length of stay for Cesarean section births is considerably longer than for vaginal births (2.9 days compared to 5.6 days). The *total* average length of stay varies across plans from 2.1 to 3.4 days.

Table 71

Discharges and Average Length of Stay - Maternity Care, 2002 Results						
	Discharges/1,000 Female Members			Average Length of Stay (Days)		
	Total	Vaginal	C-Section	Total	Vaginal	C-Section
Maryland HMO/POS Average	**24.4**	**18.1**	**6.3**	**2.7**	**2.3**	**4.0**
Aetna	26.9	19.1	7.8	2.9	2.3	4.3
BlueChoice	23.8	17.6	6.3	2.7	2.3	4.0
CIGNA	28.7	20.5	8.2	2.6	2.2	3.7
Coventry	22.0	16.4	5.7	2.6	2.2	3.7
Delmarva	22.7	17.8	5.0	2.1	1.9	2.9
Kaiser	21.1	16.7	4.3	2.8	2.5	3.9
M.D. IPA	19.1	13.5	5.6	2.8	2.2	4.1
OCI	25.3	18.8	6.6	2.6	2.2	3.8
PHN	30.1	22.8	7.3	3.4	2.7	5.6

D. CESAREAN SECTION RATE AND VAGINAL BIRTH AFTER CESAREAN SECTION (VBAC RATE)

Definition of Measures

The Cesarean Section Rate measure reports what percent of all live births were by Cesarean section (C-section) in 2001. The VBAC rate reports the percent of all women who delivered a live birth vaginally during 2001 after having a C-section for a previous delivery. Rates are expressed as a percentage.

Notes

Deliveries by C-section are among the most frequently performed surgical procedures, and whether all are medically necessary is in question. For this reason, consumers and purchasers may want to know the C-section rate of a health plan when deciding which one to choose.

Much evidence exists that a repeat Cesarean delivery is not required solely because a previous delivery by this method was performed. Armed with this knowledge many women have an interest in knowing the VBAC rate.

The factor that most complicates maternity-related HEDIS measures is identifying live births. Poor quality coding of maternity data is common throughout the industry and can complicate identifying the true number of live births.

Besides the difficulty of identifying live births, the VBAC measure also faces industry-wide difficulties in determining which members have had a prior cesarean section. Although doctors are nearly always aware of this history, that information is rarely reflected in administrative data systems. The number of conditions that physicians can describe with the coding system, combined with the limited number of VBAC codes, results in data incompleteness. In addition, this measure must be calculated using the administrative data methodology only and cannot be supplemented with medical record data.

Results

Across Maryland HMOs, 26% of all live births were by Cesarean section in 2001 (see Table 72). Rates range across plans from 21% to 30%.

Across Maryland HMOs, 30% of women who had a prior Cesarean section and gave birth in 2001 had a vaginal birth. VBAC rates ranged widely, from 17% to 60%. However, as noted above, plans often have difficulty determining if members have had a prior Cesarean section, thereby affecting the accuracy of rate calculation.

Table 72

Cesarean Section (C-Section) and Vaginal Birth After C-Section Rates, 2002 Results		
	C-Section	**VBAC**
Maryland HMO/POS Average	**26%**	**30%**
Aetna	29%	23%
BlueChoice	26%	60%
CIGNA	28%	25%
Coventry	26%	17%
Delmarva	22%	18%
Kaiser	21%	37%
M.D. IPA	30%	27%
OCI	26%	29%
PHN	24%	30%

E. OUTPATIENT DRUG UTILIZATION

Definition of Measure

This measure reports the number of prescriptions dispensed per member, per month and the average cost of prescriptions to the plan per member, per month. Only members whose benefits include prescription drug coverage through their HMOs are included. This measure excludes drugs that members are given in hospital and only includes prescriptions that are covered by the member's health plan. Because many employers "carve out" drug benefits from their contracts with health plans, these data do not reflect a true picture of drug use by all plan members.

Notes

Descriptive information about pharmacy services and drug formularies is included in this year's *Consumer Guide*. Plans accredited by NCQA have met the standards for pharmaceutical management, which includes formulary development. This information is included in The Accreditation section of the *Comprehensive Report* and contains further details.

Results

In 2001, the average commercial HMO member in Maryland received 9.0 prescriptions during the year, costing $34.00 per month (see Table 73). The number of prescriptions per year ranged widely from 6.4 per member to 12.9 per member. Similarly, the cost per member per month ranged widely from $21.82 to $51.99. This is up from the per member cost range in 2000 of $18.31 to $43.74. One plan's cost per member per month data was not reportable.

Table 73

Outpatient Drug Utilization, 2002 Results		
	Prescriptions/ Member/Year	**Cost of Prescriptions/ Member/Month**
Maryland HMO/POS Average	**9.0**	**$34.00**
Aetna	9.4	NR
BlueChoice	12.9	$51.99
CIGNA	6.4	$27.55
Coventry	9.5	$33.15
Delmarva	10.8	$37.08
Kaiser	7.1	$21.82
M.D. IPA	9.4	$40.77
OCI	7.5	$32.03
PHN	7.6	$27.64

HEALTH PLAN DESCRIPTIVE INFORMATION

VIII. HEALTH PLAN DESCRIPTIVE INFORMATION

Summary

This section presents results for Health Plan Descriptive Information measures that are part of the HEDIS measurement set that MHCC required Maryland HMOs to report in 2002. Although these are not performance measures, this information does provide some of the background necessary to interpret performance measures and to make an informed choice among health plans.

Purchasers and consumers are interested in the qualifications of doctors in their health plan as reflected by board certification and the completion of residency programs. Other health plan characteristics are also of interest. Plans compensate providers differently, which can affect referral patterns and patient satisfaction with plan performance. Member/enrollee patterns, as reflected in enrollment data, can reveal potential signs of instability. A sudden decrease in membership may indicate member dissatisfaction. Likewise, a sudden increase in membership due to merger/acquisition could suggest a potential future problem ensuring access to care and satisfaction to more members than a plan has capacity to handle. Measures in this section address all of the preceding issues.

This domain includes the following measures collected in Maryland:

Measure	Description
Board Certification/Residency Completion	The percent of physicians who are board certified and have completed residency programs.
Practitioner Compensation	How health plans pay providers.
Total Enrollment	The total number of members (member years) enrolled in the HMO.

A. BOARD CERTIFICATION/RESIDENCY COMPLETION

Background

The performance of plan doctors has a significant impact on overall quality of care delivered to health plan members. Consequently, purchasers and consumers are interested in information that will help them assess "how good" a plan's doctors are in providing needed care. Board certification is often used as a proxy to measure physician quality. Virtually all medical specialty boards certify physicians who have completed additional training and who have passed an examination in that specialty.

Some physicians have valid reasons why they have not sought and obtained board certification, and board certification alone is not a guarantee of quality. A plan might have a lower percentage of board certified physicians if the plan has a higher proportion of older physicians who began their practice before board certification was established. Similarly, a plan's rate may be lower if the plan is located in a rural area where shortage of a particular type of physician is common.

Definition of Measure

This measure reports the percentage of physician practitioners who have completed residency or fellowship training (in their respective specialties) and who are board certified. Physicians are categorized as follows:

- Primary care practitioners
- OB/GYN practitioners
- Pediatric practitioner specialists
- All other practitioner specialists

Board certification refers to the various specialty certification programs of the American Board of Medical Specialties and the American Osteopathic Association.

Notes

Please note that trending data are not presented for the Residency Completion measure. These measures are not reported in the *Consumer Guide* and, therefore, plans cannot achieve Star Performer status for these measures.

Results

Comparison of 2002 Maryland HMO/POS results across categories indicates that all provider groups show similar rates of Board Certification ranging from 81% for Pediatric Practitioner Specialists to 84% for OB/GYN (see Table 74). In each category, the average rate of certification among physicians has decreased from the average rate reported in 2001.

PCP Board Certification: From 2000 to 2002, six of the eight plans reporting for all three years improved their rates significantly (see Table 75). The Maryland HMO/POS average increased two percentage points over this period. In 2002, two plans received an average score, three plans were above average, and four plans were below average. Rates ranged from 76% to 94%. In 2001 the range was 78% to 97%.

PCP Residency Completion: In 2002, two plans received an average score, six plans were above average, and one plan was below average Rates ranged from 77% to 100% (see Table 76). In 2001 the range was 89% to 100%.

OB/GYN Board Certification: From 2000 to 2002, one out of eight plans reporting for all three years improved their rate significantly (see Table 77). The Maryland HMO/POS average decreased one percentage point over this period. In 2002, two plans received an average score, three plans were above average, and four plans were below average. Rates ranged from 74% to 95%. In 2001 the range was 78% to 99%.

OB/GYN Residency Completion: In 2002, one plan received an average score, seven plans were above average, and one plan was below average (see Table 78). Rates ranged from 80% to 100%. In 2001 the range was 91% to 100%.

In 2002, five plans received an average score, two plans were above average, and two plans were below average. Rates ranged from 53% to 100%. In 2001 the range was 55% to 100%.

Pediatrician Residency Completion: In 2002, two plans received an average score, six plans were above average, and one plan was below average (see Table 79). Rates ranged from 82% to 100%. In 2001 the range was 95% to 100%.

Other Specialists Board Certification: From 2000-2002, three out of the eight plans reporting for all three years improved their rate significantly (see Table 80). The Maryland HMO/POS average increased two percentage points over this period. However, analysis of the results for this measure indicates that the consolidation of Aetna plans contributed significantly to the change in the Maryland HMO Average from 2000 to 2002. **Changes in the Maryland HMO average should not be interpreted to arise solely from changes in plan performance.** See the Methodology section for further discussion

In 2002, no plan received an average score, four plans were above average, and five plans were below average. Rates ranged from67% to 100%. In 2001 the range was 69% to 98%.

Other Specialists Residency Completion: In 2002, one plan received an average score, six plans were above average, and two plans were below average (see Table 81). Rates ranged from 78% to 100%.

Table 74

Board Certification, 2002 Results								
	PCP		OB/GYN		Pediatric		Other Specialists	
Maryland HMO/POS Average	**84%**		**83%**		**81%**		**84%**	
Aetna	80%	○	74%	○	53%	○	67%	○
BlueChoice	76%	○	80%	○	82%	⊙	78%	○
CIGNA	83%	⊙	77%	○	67%	○	76%	○
Coventry	90%	●	91%	●	90%	●	92%	●
Delmarva	82%	⊙	77%	⊙	80%	⊙	95%	●
Kaiser	89%	●	89%	●	88%	⊙	87%	●
M.D. IPA	82%	○	82%	⊙	85%	⊙	81%	○
OCI	80%	○	80%	○	85%	⊙	81%	○
PHN	94%	●	95%	●	100%	●	100%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

Table 75

Primary Care Physician, Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**82%**	**86%**	**84%**	**2%**			
Aetna	--	78%	80%		--	○	○
BlueChoice	99%	91%	76%	🡻	●	●	○
CIGNA	81%	82%	83%	🡹	⊙	○	⊙
Coventry	87%	90%	90%	🡹	●	●	●
Delmarva	78%	84%	82%	⇔	○	⊙	⊙
Kaiser	84%	97%	89%	🡹	⊙	●	●
M.D. IPA	79%	82%	82%	🡹	○	○	○
OCI	78%	81%	80%	🡹	○	○	○
PHN	87%	95%	94%	🡹	●	●	●

Legend:

Change 2000-2002

- 🡹 Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- 🡻 Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- These measures are not reported in the *Consumer Guide* and, therefore, plans cannot achieve Star Performer status for these measures.

Table 76

Primary Care Physician Residency Completion, 2002 Results		
	2002	2002
Maryland HMO/POS Average	**96%**	
Aetna	98%	●
BlueChoice	77%	○
CIGNA	98%	●
Coventry	100%	●
Delmarva	96%	⊙
Kaiser	95%	⊙
M.D. IPA	100%	●
OCI	100%	●
PHN	99%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○= Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

Table 77

OB/GYN Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**84%**	**87%**	**83%**	**-1%**			
Aetna	--	78%	74%		--	○	○
BlueChoice	98%	96%	80%	🡻	●	●	○
CIGNA	80%	78%	77%	⇔	○	○	○
Coventry	90%	91%	91%	⇔	●	●	●
Delmarva	89%	82%	77%	⇔	⊙	⊙	⊙
Kaiser	88%	99%	89%	⇔	●	●	●
M.D. IPA	83%	82%	82%	⇔	⊙	○	⊙
OCI	82%	81%	80%	⇔	⊙	○	○
PHN	85%	99%	95%	🡹	⊙	●	●

Legend:

Change 1999 – 2001

- 🡹 Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- 🡻 Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- These measures are not reported in the *Consumer Guide* and, therefore, plans cannot achieve Star Performer status for these measures.

Table 78

OB/GYN Residency Completion, 2002 Results		
	2002	2002
Maryland HMO/POS Average	**97%**	
Aetna	100%	●
BlueChoice	80%	○
CIGNA	100%	●
Coventry	99%	●
Delmarva	100%	●
Kaiser	96%	⊙
M.D. IPA	100%	●
OCI	100%	●
PHN	99%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

Table 79

Pediatrician Residency Completion, 2002 Results		
	2002	2002
Maryland HMO/POS Average	**96%**	
Aetna	100%	●
BlueChoice	82%	○
CIGNA	99%	●
Coventry	95%	⊙
Delmarva	100%	●
Kaiser	92%	⊙
M.D. IPA	100%	●
OCI	100%	●
PHN	100%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.

Table 80

Other Board Certification, Trending							
	Comparison of Absolute Rates				*Comparison of Relative Rates*		
	2000	2001	2002	Change 2000-2002	2000	2001	2002
Maryland HMO/POS Average	**82%**	**86%**	**84%**	**2%**			
Aetna	--	69%	67%		--	○	○
BlueChocie	98%	84%	78%	↓	●	○	○
CIGNA	76%	74%	76%	⇔	○	○	○
Coventry	86%	91%	92%	↑	●	●	●
Delmarva	91%	90%	95%	↑	●	●	●
Kaiser	91%	98%	87%	↓	●	●	●
M.D. IPA	82%	83%	81%	⇔	⊙	○	○
OCI	81%	83%	81%	⇔	○	○	○
PHN	83%	94%	100%	↑	⊙	●	●

Legend:

Change 1999 – 2001

- ↑ Plan's rate increased significantly from 2000 to 2002
- ⇔ Plan's rate did not change significantly from 2000 to 2002
- ↓ Plan's rate decreased significantly from 2000 to 2002

Relative Rates

- ● = Plan performed significantly better than the Maryland HMO/POS average
- ⊙ = Plan performed equivalent to the Maryland HMO/POS average
- ○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- "Change 2000-2002" indicates a statistically significant change in a plan's absolute rate (i.e., the number of percentage points higher or lower) from 2000 to 2002.
- Relative rates represent statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.
- These measures are not reported in the *Consumer Guide* and, therefore, plans cannot achieve Star Performer status for these measures.

Table 81

Other Residency Completion, 2002 Results		
	2002	2002
Maryland HMO/POS Average	**96%**	
Aetna	100%	●
BlueChoice	78%	○
CIGNA	99%	●
Coventry	97%	●
Delmarva	97%	⊙
Kaiser	93%	○
M.D. IPA	100%	●
OCI	100%	●
PHN	100%	●

Legend:

Relative Rates

● = Plan performed significantly better than the Maryland HMO/POS average
⊙ = Plan performed equivalent to the Maryland HMO/POS average
○ = Plan performed significantly worse than the Maryland HMO/POS average

Notes:

- Relative rates are statistically significant differences between an individual plan's rate and the state HMO/POS average for a given reporting year.
- Aetna US Healthcare, Inc. – Maryland, DC, Virginia reported for the first time in 2001.

B. PRACTITIONER COMPENSATION

Background

Health plans compensate providers through a number of different payment arrangements. Research is ongoing about how certain types of payment arrangements might influence physician behavior. Fee-for-service arrangements are believed to provide doctors with an incentive for overutilization since they are paid for each medical service. Conversely, there is concern that capitation arrangements (one payment per month per member, regardless of frequency or volume of services provided) give doctors an incentive for underutilization since they are paid whether or not any service is provided. In addition, capitated providers may choose not to submit encounter data since an encounter is not associated with any payment. Although all health plans have mandated in providers' contracts that encounter data must be submitted, the requirement is often not enforced. In addition, ensuring provider compliance with these data submission requirements is difficult.

Many health plans have implemented additional incentive programs to prevent over and underutilization as well as to ensure data submission. Information on provider compensation arrangements is thought to be sufficiently important that Maryland law requires health plans to disclose in health plan marketing materials how plans pay physicians.

Definition of Measure

This measure shows what percent of primary care providers are compensated under each type of payment arrangement.

Notes

The table indicates the percent of physicians paid under each type of payment arrangement. It does not provide any information regarding the number or percent of plan members who see physicians who are compensated under each payment arrangement. For example, even if 95 percent of a plan's providers were paid fee-for-service, the remaining five percent of providers might see the majority of a plan's members.

Results

Maryland health plans compensate primary care providers through capitation and fee-for-service mechanisms (see Table 82). No plans reported using salary or "other" arrangements.

Four of the nine reporting plans reimburse physicians almost solely through fee-for-service arrangements. Two plans almost solely have capitation arrangements with their physicians. Other plans employ a varying mix of capitation and fee-for-service reimbursement.

Table 82

Practitioner Compensation, 2002 Results (Primary Care Providers)				
	Percent of Providers with the Following Compensation Arrangements			
	Fee-for-Service	Capitated	Salaried	Other
Aetna	66%	34%	0%	0%
BlueChoice	100%	0%	0%	0%
CIGNA	54%	46%	0%	0%
Coventry	100%	0%	0%	0%
Delmarva	100%	0%	0%	0%
Kaiser	25%	75%	0%	0%
M.D. IPA	8%	92%	0%	0%
OCI	18%	82%	0%	0%
PHN	100%	0%	0%	0%

C. TOTAL ENROLLMENT

Background

Enrollment information indicates the size of the health plan. Being aware of the size of each health plan may be useful in interpreting some results presented in previous sections. Health plan size is not directly associated with quality. Enrollment information is an additional piece of data for consumers and purchasers to consider in comparing health plans.

Definition of Measure

This measure shows the number of member years contributed by enrollees for each health plan in 2001. Member years are closely associated with the number of members in the health plan.

Notes

Enrollment figures are for each plan's entire population for the age groups noted. This number includes Maryland residents and enrollees residing in service areas of Washington, D.C., Northern Virginia, Richmond, Delaware, Southern New Jersey, Southeastern Pennsylvania and West Virginia.

Enrollment figures for all plans, except Kaiser, include Point of Service products, as well as HMO products. Kaiser reports HEDIS rates based on the HMO product alone.

Results

The total HMO/POS enrollment for Maryland commercial/HMO plans is estimated at 2.1 million with the average plan having approximately 240,000 members (see Table 83). Plan membership ranges widely from 18,104 to 473,314.

During calendar year 2001, total HMO enrollment (as reported in HEDIS) decreased by approximately 250,000 members, a result of FreeState, GWU Health Plan and United not reporting in 2002. (United still had approximately 50,000 commercial members in calendar 2001, although that was less than one-third of the plan's membership, thus making it exempt from reporting to MHCC. FreeState continued to operate a commercial HMO during 2001 too, although only for existing contracts. The number of members, which included State of Maryland employees, is not known by MHCC.)

For calendar year 2000, as reported in 2001, these three plans accounted for over 350,000 members. Many of these members transferred to another commercial HMO. This is reflected in the fact that the average HMO/POS plan enrollment increased by 44,000 members for 2002. Five plans increased in enrollment and four plans decreased in enrollment. The plans with the largest enrollment increases were BlueChoice (66,643)

and OCI (54,973). The increase in BlueChoice is a result of CareFirst moving members from FreeState and Delmarva into BlueChoice, which is also a CareFirst-owned plan.

Table 83

Total Enrollment (Member Years) in 2001													
	Ages 0-19			Ages 20-44			Ages 45-64			Ages 65+			Total
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Maryland HMO/POS Average	**38,389**	**36,909**	**75,299**	**46,348**	**55,389**	**101,736**	**29,225**	**32,483**	**61,707**	**2,757**	**2,683**	**5,441**	**244,183**
Maryland Total	**345,505**	**332,185**	**677,690**	**417,129**	**498,497**	**915,626**	**263,021**	**292,345**	**555,366**	**24,817**	**24,148**	**48,965**	**2,148,682**
Aetna	80218	77,465	157,683	90,718	110,746	201,464	54,671	59,496	114,167	4,100	3,478	7,578	480,892
BlueChoice	35022	33,876	68,898	49,418	63,366	112,784	27,140	33,531	60,671	3,984	4,727	8,711	251,064
CIGNA	29639	28,228	57,867	41,451	42,803	84,254	20,053	19,128	39,181	793	524	1,317	182,619
Coventry	16454	15,607	32,061	18,081	21,688	39,769	12,487	13,724	26,211	1,477	1,386	2,863	100,904
Delmarva	2469	2,367	4,836	3,157	3,901	7,058	2,847	3,363	6,210	301	263	564	18,668
Kaiser	73454	71,081	144,535	84,678	102,896	187,574	62,321	72,016	134,337	6,629	6,811	13,440	479,886
M.D. IPA	26239	24,982	51,221	25,241	32,578	57,819	20,921	22,868	43,789	2,709	2,607	5,316	158,145
OCI	71525	68,513	140,038	90,809	103,631	194,440	55,493	59,254	114,747	4,469	4,077	8,546	457,771
PHN	10485	10,066	20,551	13,576	16,888	30,464	7,088	8,965	16,053	355	275	630	67,698

USE OF FACILITIES

IX. USE OF FACILITIES

Summary

This section contains results for the HEDIS Use of Services measures and descriptive and performance indicators related to facilities utilization that MHCC required Maryland commercial HMOs to report in 2002. These measures address rates of utilization for inpatient (acute and non-acute care), ambulatory care (outpatient visits, emergency department visits and ambulatory surgeries), and provide a summary of urgent care/after hours clinical services.

This section includes the following measures collected in Maryland:

Measure	Description
Inpatient Utilization – General Hospital/Acute Care	The rate of discharges (per 1,000 members) and average length of stay for acute inpatient services.
Ambulatory Care	Members' use of ambulatory services, including outpatient visits, emergency department visits, and ambulatory surgeries, shown as rates per 1,000 members.
Inpatient Utilization – Non-acute Care	The rate of discharge (per 1,000 members) and average length of stay for non-acute inpatient services.
Urgent Care/After Hours Clinical Services	A summary of urgent care/after hours clinical service, including the number of urgent care centers available, the number of visits to urgent care (per 1,000 plan members) that each plan reported for calendar 2001,and methods for informing providers and members about urgent care services.

A. INPATIENT UTILIZATION – GENERAL HOSPITAL/ACUTE CARE

Definition of Measure

This measure reports the rate of utilization of general hospitals for treatment of acute conditions and the average length of stay. Rates are reported separately for all patients (Total), medical patients (Medicine), and surgical patients (Surgery). Information on maternity utilization can be found in the "Discharges and Average Length of Stay – Maternity Care" measure.

Notes

When interpreting this information, it is important to remember that these results are not risk-adjusted for demographic characteristics or severity of the illness. Neither availability nor use of outpatient alternatives is considered.

Results

Among Maryland HMOs, utilization rates vary widely across plans. Surgical discharges range from 10.7 discharges per 1,000 members to 25.9 discharges per 1,000 members. Rates for medical discharges range from 17.5 per 1,000 members to 38.6 per 1,000 members. Average length of stay varies less widely, ranging from 2.9 to 4.2 days for medical patients and 3.8 to 5.1 days for surgical patients (see Table 84).

Table 84

Inpatient Utilization--General Hospital/Acute Care, 2002 Results						
	Discharges/1,000 Members			Average Length of Stay (Days)		
	Total	Medical	Surgical	Total	Medical	Surgical
Maryland HMO/POS Average	**59.6**	**27.1**	**17.6**	**3.7**	**3.6**	**4.5**
Aetna	62.4	28.6	17.9	3.7	3.8	4.3
BlueChoice	57.9	31.3	10.7	3.9	4.2	4.7
CIGNA	58.0	26.9	15.0	3.7	3.8	4.6
Coventry	58.9	25.5	17.8	3.9	3.7	4.8
Delmarva	78.0	38.6	25.9	3.6	3.4	4.5
Kaiser	42.4	17.5	12.7	3.9	3.8	5.1
M.D. IPA	53.9	23.4	18.4	3.3	3.0	4.2
OCI	57.4	23.5	18.1	3.4	2.9	4.6
PHN	67.1	28.4	22.1	3.6	3.3	3.8

Totals also include maternity discharges and average lengths of stay, which are not shown as separate categories in the table.

B. AMBULATORY CARE

Definition of Measure

This measure reports members' use of ambulatory services including outpatient visits, emergency department visits, and ambulatory surgeries. Rates are per 1,000 members.

Notes

An outpatient visit is defined as a face-to-face encounter between the practitioner and patient for routine care. It provides a reasonable proxy for professional ambulatory encounters.

Emergency department visits may sometimes be used as a substitute for ambulatory clinic encounters. Although patient behavior is a factor in the decision to use an emergency department rather than a clinic or physician's office, the decision also may result from insufficient access to primary care. A health plan that provides adequate preventive services and effectively manages ambulatory treatment of patients by offering alternative treatment benefits, such as urgent care coverage, should be able to keep the number of emergency room visits relatively low.

Ambulatory surgeries include procedures performed at a hospital outpatient facility, or at a freestanding surgery center; office-based surgeries/procedures are excluded from this measure.

The increasing use of outpatient surgery as an alternative to inpatient surgical procedures can create data interpretation issues. For hospital organizations with semi-attached ambulatory surgery centers, the distinction between place of service may be confused during data processing.

Results

The majority of ambulatory services are outpatient visits (see Table 85). Rates of outpatient visits per 1,000 members vary widely across plans, ranging from 3,130 to 4,368. The average across all Maryland plans was 3,562, up from 3,285 per 1,000 members for the previous year.

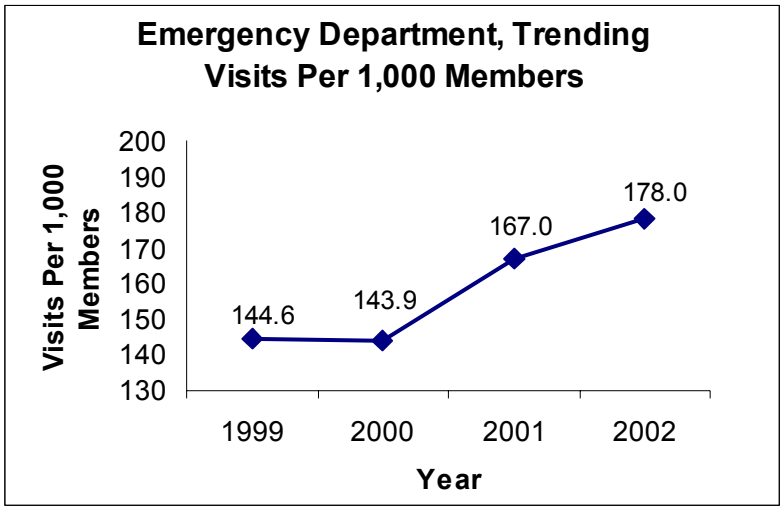
Emergency department visits range from 85 per 1,000 members to 244 per 1,000 members. The Maryland HMO/POS average rate of ED use was 178 per 1,000 members, up from 167 per 1,000 members for 2001 (see Table 86).

Ambulatory surgery rates range from 47 per 1,000 members to 145 per 1,000 members. The average rate was 94 per 1,000 members. This was an increase from 92 per 1,000 members for 2001.

Table 85

Ambulatory Care, 2002 Results			
	Visits/1,000 Members		
	Outpatient Visits	ER Visits	Amb. Surgery
Maryland HMO/POS Average	**3,562**	**178**	**94**
Aetna	3,269	190	82
BlueChoice	3,419	182	76
CIGNA	3,141	219	76
Coventry	3,847	151	120
Delmarva	4,072	244	145
Kaiser	4,368	85	47
M.D. IPA	3,465	169	108
OCI	3,130	172	95
PHN	3,346	189	99

Table 86



C. INPATIENT UTILIZATION NON-ACUTE CARE

Definition of Measure

This measure reports the rate of utilization and average length of stay for inpatient non-acute care. Inpatient non-acute care includes inpatient care received in the following facilities: hospice, nursing home, rehabilitation, skilled nursing facilities, transitional care and respite. Mental health and chemical dependency facilities are excluded. Rates are per 1,000 members.

Notes

When interpreting this information, it is important to remember that results are not risk-adjusted for demographic characteristics and use of outpatient alternatives. Data completeness can be a significant issue for many plans when generating this measure, often leading to underreporting.

Results

The rate of inpatient non-acute stays per 1,000 members varies across plans from 0.6 to 3.1 (see Table 87). Average length of stay ranges from 9.4 days to 20.0 days. The average LOS across all plans was 14.4, compared to 14.1 for the previous year.

Table 87

Inpatient Utilization--Nonacute Care, 2002 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**1.4**	**14.4**
Aetna	1.5	13.5
BlueChoice	1.3	15.5
CIGNA	0.8	20.0
Coventry	0.8	16.3
Delmarva	1.5	15.0
Kaiser	3.1	9.4
M.D. IPA	1.5	15.4
OCI	1.4	14.5
PHN	0.6	9.6

D. URGENT CARE/AFTER HOURS CLINICAL SERVICES

Background

Every health plan is obligated to have arrangements in place for members to receive urgently needed medical care outside of physicians' normal office hours. Physicians also agree to arrange for coverage by another physician when they are not available to their patients.

Health plans vary in how they handle after-hours care. Some plans report that they operate, or contract with, urgent care facilities; others do not. In some cases, members are advised to go to a hospital emergency department if their physician is not available, even during normal business hours. Other plans require members to call the plan and be referred for care. All plans advise members to go directly to an emergency room, if their condition is critical. Although commercial HMO members account for a third of ER visits, in relation to the large percent of the population enrolled in HMOs, they do not contribute disproportionately to emergency department use.

Of course, people become ill at all hours of the day and night. Hospital emergency departments are used not only for life-saving medical services, but also often as the most convenient place to refer ill patients when a regular source of care is not available within a short period of time. The result is that many emergency departments of hospitals are often crowded with patients who are not in a medical crisis that requires immediate attention. Emergency care in a hospital setting is expensive, both for the health care system and for individual members who may incur hefty copayments for ER visits. Long delays for everyone result when emergency departments are used as primary care clinics.

Definition of Measure

This measure was required to be reported by Maryland commercial HMOs for the first time in 2002. Plans have been informed that this measure is of continued interest to MHCC, and will be collected again in 2003. Criteria will be further refined to ensure that all plans use the same definitions for visits. It shows a summary of how Maryland health plans provided an established source of evening and weekend care (not including telephone advice) for members who are ill as follows:

- Whether the HMO contracts with or operates urgent care centers that are available to members at any time between 5:00 p.m. and 9:00 p.m. during the week or between 9:00 a.m. and 5:00 p.m. on weekends
- The number of urgent care centers in the HMO's network and service area available to members for any portion of the days and hours specified above. The total number of hours all network urgent care centers are available to members during these time periods: Monday to Friday, 5:00 p.m. to 9:00 p.m. AND Saturday to Sunday, 9:00 a.m. to 5:00 p.m. (Each urgent care center could be available as much as 36 hours.)
- The percentage of the 36 hours, per center, referenced above, that urgent care centers are available during evening and weekend hours.
- The total number visits by members to urgent care centers during 2001.

- The methods by which plan providers are informed of the availability of network urgent care centers where members may be referred.
- The methods by which plan members are informed of the availability of network urgent care centers.

Notes

Delmarva does not operate urgent care facilities or contract with another entity to provide these services.

Results

Eight of the nine plans in this report have a contract with urgent care centers.

The Maryland HMO/POS average for weekend & evening hours when urgent care center sites are open in 2001 was 71% (see Table 88). Rates ranged from 43% to 96% (excluding Delmarva).

Plans employed various methods to inform providers and members about after hour care, including manuals/reference guides, provider directory, newsletter, Web site and customer service (see Tables 89 and 90, respectively).

Table 88

Urgent Care/After Hours Clinical Services, 2002 Results				
	Number of Urgent Care Centers in Network	Total Number of Hours Urgent Care Centers Available	Maximum Possible Urgent Care Hours	Percentage Urgent Care Hour
Maryland HMO/POS Average	**26**	**722**	**928**	**71%**
Aetna	13	449	468	96%
BlueChoice	5	169	180	94%
CIGNA	26	737	936	79%
Coventry	4	62	144	43%
Delmarva	0	0	0	0%
Kaiser	19	619	684	90%
M.D. IPA	83	2,233	2,988	75%
OCI	70	1,855	2,520	74%
PHN	12	373	432	86%

Notes:

- *Number of Urgent Care Centers in Network*: The number of urgent care centers in the HMO's network and service area available to members for any portion of the days and hours specified.
- *Total Number of Hours Urgent Care Available*: The total number of hours **all** network urgent care centers are available to members during these time periods: Monday to Friday, 5:00 p.m. to 9:00 p.m. AND Saturday to Sunday, 9:00 a.m. to 5:00 p.m. (This could total as much as 36 hours per center.)
- *Maximum Possible Urgent Care Hours:* The maximum hours that urgent care centers could be available for evening and weekend care.
- *Percentage Urgent Care Hour:* The percentage of hours that urgent care centers are available during evening and weekend hours.

Delmarva does not operate urgent care facilities or contract with another entity to provide these services and, therefore, is not included in the table.

Table 89

Urgent Care/After Hours Clinical Services, 2002 Results Informing Providers About Urgent Care					
	Provider Manual	Provider Directory	Provider Newsletter	Website	Provider Services
Aetna		✓	✓		
BlueChoice		✓	✓	✓	✓
CIGNA		✓	✓		
Coventry		✓	✓	✓	
Delmarva	-	-	-	-	-
Kaiser	✓			✓	✓
M.D. IPA	✓				
OCI	✓				
PHN		✓	✓	✓	✓

The methods by which a plan's providers are informed of the availability of network urgent care centers where members may be referred.

Table 90

Urgent Care/After Hours Clinical Services, 2002 Results Informing Members About Urgent Care					
	Member Reference Guide	Provider Directory	Member Newsletter	Website	Member Services
Aetna		✓			
BlueChoice		✓	✓	✓	✓
CIGNA		✓	✓		
Coventry		✓	✓	✓	
Delmarva	-	-	-	-	-
Kaiser		✓		✓	✓
M.D. IPA	✓		✓	✓	
OCI	✓		✓	✓	
PHN		✓	✓	✓	✓

The methods plans use to advise members of the availability of network urgent care centers.

Notes:

Delmarva does not operate urgent care facilities or contract with another entity to provide these services.

BEHAVIORAL HEALTH SERVICES

X. BEHAVIORAL HEALTH SERVICES

Summary

This section contains MHCC-specific performance results for HEDIS Use of Services measures and performance indicators related to behavioral health that MHCC required Maryland commercial HMOs to report in 2002. These measures were recommended by the Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (MBHOs) and MHCC. MHCC-specific performance reporting requires that each HMO provide information on the behavioral health providers that specifically serve the same geographic area that is served by the health plan.

As MBHOs play an increasingly significant role in Maryland's health care system, a closer look is warranted. MBHOs are separate organizations that contract with health plans or employers to provide only mental health care and chemical dependency services. In recent years, it has become common for health plans to contract-out some specialized services rather than to provide them to their members directly. Like laboratory and radiology services, behavioral health services are often provided by a separate company. When health plans contract with another company to provide services, the health plan remains legally responsible for ensuring the quality of care provided by that contractor, the MBHO. Utilization data for people who received behavioral health services via a separate contract between their employer and a MBHO or through a private arrangement are not included here.

This section includes the following measures collected in Maryland:

Measure	Description
Mental Health Utilization – Inpatient Discharges and Average Length of Stay (MHCC-Specific Performance Measure)	A summary of hospitalizations, per 1,000 members, for mental health disorders and the average length of stay.
Mental Health Utilization – Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services (MHCC-Specific Performance Measure)	The percent of members with mental health benefits who received any mental health services during the measurement year.
Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay (MHCC-Specific Performance Measure)	Hospitalizations, per 1,000 members, for inpatient chemical dependency services and the average length of stay.
Chemical Dependency Utilization – Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services (MHCC-Specific Performance Measure)	The percent of members with chemical dependency benefits who received any chemical dependency services during the measurement year.
Behavioral Health Provider Network (MHCC-Specific Performance Measure)	The number of various types of providers, per 1,000 members, in the behavioral health network of providers and the percentage of network psychiatrists who are board-certified as of the close of business on December 31, 2001

A. MENTAL HEALTH UTILIZATION – INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY (MHCC-SPECIFIC PERFORMANCE MEASURE)

Definition of Measure

This MHCC-specific performance measure, which is part of the HEDIS Use of Services domain, estimates how many hospitalizations for mental health disorders occurred during 2001 and how long patients stayed in the hospital, on average. The measure includes only members whose coverage with their health plan included mental health benefits. If the health plan contracts with another provider, the plan is responsible for collecting and reporting those data. Rates are per 1,000 members with mental health coverage. Some employers contract separately for mental health and chemical dependency services, commonly referred to as behavioral health services. Data are not included here if members receive services outside their health plan, as a result of behavioral health services being excluded from their coverage by their health plan.

Notes

Ensuring the quality of behavioral health data from vendors and compiling it with internal mental health and chemical dependency service information has not been an area of plan strength. As a result, data completeness issues can decrease plan utilization rates.

Results

The Maryland HMO/POS average rate of hospitalizations for all mental disorders was 2.8 discharges per 1,000 members (see Table 91). Rates varied from 1.9 discharges per 1,000 members to 3.5 discharges per 1,000 members. Average length of stay ranged from 3.5 days to 7.6 days, a greater spread than the 4.1 and 6.9, respectively, in 2001. Table 92 shows that the rate of hospitalization was the same (.23%) for members under 18 as it was for adults.

Table 91

Mental Health Utilization -- Inpatient Discharges and Average Length of Stay, 2002 Results		
	Discharges/1,000 Members	ALOS (Days)
Maryland HMO/POS Average	**2.8**	**6.1**
Aetna	3.3	6.0
BlueChoice	2.4	6.0
CIGNA	3.2	6.5
Coventry	2.5	3.5
Delmarva	2.0	7.1
Kaiser	3.3	6.1
M.D. IPA	3.5	6.3
OCI	3.4	5.5
PHN	1.9	7.6

Table 92

Mental Health Utilization - Inpatient Services, 2002 Results				
	0-17 years M&F		18-65+ years M&F	
	Num	Pct	Num	Pct
Maryland HMO/POS Average	**190**	**0.23%**	**486**	**0.24%**
Aetna	317	0.22%	908	0.27%
BlueChoice	122	0.19%	357	0.19%
CIGNA	73	0.18%	269	0.28%
Coventry	72	0.25%	140	0.19%
Delmarva	NA	NA	NA	NA
Kaiser	276	0.21%	758	0.22%
M.D. IPA	108	0.30%	263	0.31%
OCI	359	0.28%	1,122	0.34%
PHN	NA	NA	71	0.14%

Notes:

- M&F=Male and Female
- NA = The plan had an insufficient number of members, i.e., fewer than 50, to report this measure.

B. MENTAL HEALTH UTILIZATION – PERCENT OF MEMBERS RECEIVING ANY SERVICES (MHCC-SPECIFIC PERFORMANCE MEASURE)

Definition of Measure

This MHCC-specific performance measure, which is part of the HEDIS Use of Services domain, reports the portion of members who received the following types of mental health services:

- hospital treatment (inpatient).
- day/night care (a level of intermediate care where a patient may live at home and visit a therapeutic institution during the day).
- ambulatory treatment.

This measure also provides information about access to mental health services. Rates are expressed as a percentage.

Results

Across Maryland HMOs, 5.5% of all members with behavioral health coverage received some type of behavioral health service in 2001 (see Table 93). Plan rates ranged from 3.7% to 7.3%.

Rates of hospital treatment (inpatient), day/night care and ambulatory treatment are presented in Table 93 on the following page. These rates are included in the report to facilitate comparison and analysis by plans, providers, and other organizations. There are minimal differences across plans, as rates for each type of service are less than 1%.

Table 93

Mental Health Utilization - Percent of Members Receiving Services, 2002 Results								
	Any Services M&F		Inpatient Services M&F		Day/Night Services M&F		Ambulatory Services M&F	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**12,691**	**5.46%**	**656**	**0.24%**	**250**	**0.07%**	**12,520**	**5.39%**
Aetna	28,836	6.00%	1,225	0.25%	310	0.06%	28,552	5.94%
BlueChoice	18,103	7.21%	479	0.19%	NA	NA	17,609	7.01%
CIGNA	7,085	5.10%	342	0.25%	NA	NA	6,968	5.02%
Coventry	7,322	7.26%	212	0.21%	NA	NA	7,268	7.20%
Delmarva	753	4.03%	NA	NA	NA	NA	748	4.01%
Kaiser	17,890	3.73%	1,034	0.22%	267	0.06%	17,507	3.65%
M.D. IPA	6,861	5.73%	371	0.31%	100	0.08%	6,838	5.71%
OCI	24,152	5.31%	1,481	0.33%	323	0.07%	24,004	5.28%
PHN	3,219	4.75%	101	0.15%	NA	NA	3,184	4.70%

Note: The sum of the number of members who receive various services does not equal the number of members who received any service due to many members receiving more than one type of service.

C. CHEMICAL DEPENDENCY UTILIZATION – INPATIENT DISCHARGES AND AVERAGE LENGTH OF STAY (MHCC-SPECIFIC PERFORMANCE MEASURE)

Definition of Measure

This MHCC-specific performance measure, which is part of the HEDIS Use of Services domain, reports how many hospitalizations for chemical dependency occurred during 2001 and how long patients stayed in the hospital, on average. The single most common type of treatment sought is for alcohol dependence. The measure includes only members whose health care benefits include coverage for chemical dependence. Rates are per 1,000 members with chemical dependency coverage.

Notes

National statistics from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA) reveal that in 1999 there were 760,721 admissions for primary treatment of alcohol. This number represents 46 percent of the approximately 1.6 million substance abuse treatment admissions in that year.

As is the case for all data related to behavioral health, the quality of data on use of chemical dependency services may reflect underreporting. Data collection problems are connected to how these services are delivered, often via contractors, or private arrangements, rather than through health plans.

Results

The Maryland HMO/POS average was the same as last year at 0.8 discharges per 1,000 members (see Table 94). Rates ranged widely from 0.2 discharges per 1,000 members to 1.2 discharges per 1,000 members. Average length of stay ranged from 1.0 day to 5.5 days.

Table 94

Chemical Dependency Utilization -- Inpatient Discharges and Average Length of Stay, 2002 Results		
	Discharges/1,000 Members	**ALOS (Days)**
Maryland HMO/POS Average	**0.8**	**3.8**
Aetna	0.7	3.5
BlueChoice	1.1	3.4
CIGNA	0.6	3.7
Coventry	0.6	3.6
Delmarva	0.2	1.0
Kaiser	1.2	4.3
M.D. IPA	1.0	4.8
OCI	1.1	4.3
PHN	0.8	5.5

D. CHEMICAL DEPENDENCY UTILIZATION – PERCENT OF MEMBERS RECEIVING ANY SERVICES (MHCC-SPECIFIC PERFORMANCE MEASURE)

Definition of Measure

This MHCC-specific performance measure, which is part of the HEDIS Use of Services domain, reports the percentage of members who received chemical dependency services in the following intensity levels:

- hospital treatment (inpatient).
- day/night care.
- ambulatory treatment.

This measure also provides information about access to chemical dependency services. Rates are expressed as a percentage.

Notes

Receipt of mental health and chemical dependency service information from behavioral health vendors can be problematic. As a result, data completeness issues can affect plan utilization rates.

Results

Across Maryland HMOs, 0.4% of all members with chemical dependency coverage through their health plan, received chemical dependency services in 2001 (see Table 95). Rates ranged from 0.2% to 0.5%.

Results for hospital treatment (inpatient), day/night care, and ambulatory treatment are presented in the tables on the following pages. These rates are included in the report to facilitate comparison and analysis by plans, providers and other organizations. There are minimal differences across plans as all rates are less than 1%.

Table 95

Chemical Dependency Utilization - Percent of Members Receiving Services, 2002 Results								
	Any Services M&F		Inpatient Services M&F		Day/Night Services M&F		Ambulatory Services M&F	
	Num	Pct	Num	Pct	Num	Pct	Num	Pct
Maryland HMO/POS Average	**929**	**0.37%**	**202**	**0.07%**	**182**	**0.04%**	**830**	**0.32%**
Aetna	2,041	0.42%	282	0.06%	181	0.04%	1,855	0.39%
BlueChoice	461	0.18%	181	0.07%	NA	NA	279	0.11%
CIGNA	481	0.35%	86	0.06%	NA	NA	419	0.30%
Coventry	367	0.36%	55	0.05%	NA	NA	332	0.33%
Delmarva	71	0.38%	NA	NA	NA	NA	53	0.28%
Kaiser	2,352	0.49%	389	0.08%	217	0.05%	2,042	0.43%
M.D. IPA	428	0.36%	76	0.06%	NA	NA	419	0.35%
OCI	1,941	0.43%	347	0.08%	147	0.03%	1,879	0.41%
PHN	216	0.32%	NA	NA	NA	NA	196	0.29%

Note: The sum of the number of members who receive various services does not equal the number of members who received any service due to many members receiving more than one type of service.

Table 96

Chemical Dependency Utilization - Ambulatory Services, 2002 Results				
	0-17 years M&F		18-65+ years M&F	
	Num	Pct	Num	Pct
Maryland HMO/POS Average	**147**	**0.19%**	**795**	**0.37%**
Aetna	219	0.15%	1,636	0.49%
BlueChoice	35	0.06%	244	0.13%
CIGNA	60	0.14%	359	0.37%
Coventry	85	0.30%	247	0.34%
Delmarva	NA	NA	NA	NA
Kaiser	332	0.26%	1,710	0.49%
M.D. IPA	57	0.16%	362	0.43%
OCI	238	0.19%	1,641	0.50%
PHN	NA	NA	162	0.33%

Notes:

- M&F=Male and Female
- NA = The plan had an insufficient number of members, i.e., fewer than 50, to report this measure.

E. BEHAVIORAL HEALTH PROVIDERS (MHCC-SPECIFIC PERFORMANCE MEASURE)

Background

In recent years, a number of changes have occurred in the way behavioral health services are delivered and paid for. Most importantly, many health plans now contract with MBHOs to provide care to some or all of their members. These organizations, specializing in providing mental health and chemical dependency services, have their own network of physicians and other behavioral health practitioners. MBHOs can also have specific rules for accessing behavioral health services including the need for a referral, limits on coverage, and co-payments that may be different than the HMO's.

If a plan does not contract with an MBHO, the plan provides behavioral health services within its network of providers. Sometimes, consumers who have coverage for behavioral health services do not know what company is responsible for providing those services. When care is delivered and no problems arise, the contractual relationship between an HMO and an MBHO may be transparent to members. Obtaining referrals from their health plan for behavioral health services has been an area of great concern by members of HMOs.

Definition of Measure

This MHCC-specific performance measure reports the number of various types of providers (for each discipline) in the behavioral health network of providers and the percentage of network psychiatrists who are board-certified as of the close of business on December 31, 2001. The behavioral health network includes all providers of behavioral health care to *commercial* enrollees. Providers may be employed by the HMO, have a contractual relationship with the HMO, or have a contractual relationship with the MBHO responsible for managing and providing care for the HMO's enrollees. The provider types are:

- psychiatrists
- psychologists
- social workers
- nurse psychotherapists
- certified professional counselors
- other behavioral health providers

Results

The measure shows a comparison of the provider network available to members of the various plans. Because the number of providers would be greater for a plan with many members, the number of providers available is compared for an equal number of members across each plan, providers per 1,000 members. A larger number of providers improves access to care by giving members more choices in who they see, appointment times, and locations.

The number of behavioral health providers in the MBHO and plan network of December 31, 2001:

Psychiatrists (M.D.s): The Maryland HMO/POS average for number of psychiatrists (M.D.s) is 2.2 per 1,000 members (see Table 97). Rates ranged from 0.1 to 5.2 per 1,000 members.

Psychologists (Ph.D.s): The Maryland HMO/POS average for number of psychologists (Ph.D.s) is 2.2 per 1,000 members (see Table 97). Rates ranged from 0.1 to 4.5 per 1,000 members.

Other Providers: The Maryland HMO/POS average for number of other providers is 5.1 per 1,000 members (see Table 97). Rates ranged from 0.2 to 11.0 per 1,000 members.

Total Providers: The Maryland HMO/POS average for number of total providers is 9.5 per 1,000 members (see Table 97). Rates ranged from 0.4 to 24.9 per 1,000 members.

Psychiatrists (M.D.s)

Board Certification: The Maryland HMO/POS average for the percent of psychiatrists who are board certified psychiatrists (M.D.s) is 73% (see Table 98). Rates ranged from 56% to 100%.

Table 97

Health Plan - MBHO	Number of Behavioral Health Providers in MBHO and Plan Network on 12/31/01 (per 1000 HMO/POS Members)			
	Psychiatrists (M.D.s)	Psychologists (Ph.D.s)	Other Providers	Total Providers
Maryland HMO/POS Average	**2.2**	**2.2**	**5.1**	**9.5**
Aetna - Magellan	0.9	1.4	4.0	6.3
BlueChoice – Magellan*	1.3	2.1	6.0	9.5
BlueChoice – ValueOptions	1.5	1.4	3.5	6.5
CIGNA - CIGNA Behavioral Health	0.8	0.8	2.1	3.6
Coventry - APS	0.1	0.1	0.2	0.4
Delmarva - Magellan	1.0	0.6	3.2	4.8
Kaiser - APS	3.3	4.5	11.0	18.7
Kaiser – KPMAS/Magellan **	0.5	0.7	1.9	3.0
M.D. IPA – M.D. IPA	5.2	4.3	9.8	19.4
OCI - OCI	1.9	1.6	3.6	7.2
PHN - APS	7.7	6.5	10.7	24.9

Table 98

Health Plan - MBHO	Percent of Psychiatrists Who are Board Certified
Maryland HMO/POS Average	**73%**
Aetna - Magellan	68%
BlueChoice – Magellan*	69%
BlueChoice – ValueOptions	56%
CIGNA - CIGNA Behavioral Health	73%
Coventry - APS	82%
Delmarva - Magellan	68%
Kaiser - APS	61%
Kaiser – KPMAS/Magellan **	81%
M.D. IPA – M.D. IPA	75%
OCI - OCI	75%
PHN - APS	100%

Notes:

- * BlueChoice, FreeState Health Plan, and Delmarva used the Magellan network as of 12/31/01. The number of members used in determining the ratio of providers to members includes members of all three CareFirst plans.
- ** In 2002, Kaiser did not contract with Magellan.

EXTERNAL ACCREDITATION
&
FINANCIAL RATINGS

XI. EXTERNAL ACCREDITATION & FINANCIAL RATINGS

Accreditation status indicates the outcome of an independent external assessment of health plan quality by a review organization. The National Committee for Quality Assurance (NCQA), the American Accreditation Healthcare Commission (URAC), and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) accredit health plans. However, JCAHO does not accredit any plans appearing in this report. As part of its accreditation process, NCQA reviews pharmacy policies that include formulary development and management.

Managed behavioral health care organizations (MBHOs) are accredited by NCQA, JCAHO, and URAC. The accredited health care organizations included in this report have sought quality review of their firms voluntarily. In the State of Maryland, accreditation is not required for health plans or managed behavioral health care organizations.

A. HEALTH PLAN ACCREDITATION

The following table identifies the accreditation status of each Maryland health plan and identifies the accrediting organization.

Maryland Health Plan Accreditation Status	
Maryland HMO/POS	**Accreditation Organization - Status; Expiration Date**
Aetna	NCQA - Excellent; Expires 02/05
BlueChoice	NCQA - Excellent; Expires12/04
CIGNA	NCQA - Excellent; Expires 09/03
Coventry	URAC - Full; Expires 06/04
Delmarva	Not accredited
Kaiser	NCQA - Commendable; Expires 08/04
M.D. IPA	NCQA - Excellent; Expires 06/03
OCI	NCQA - Excellent; Expires 06/03
PHN	Not accredited

The health plan accreditation processes and standards employed by NCQA, URAC, and JCAHO are described below.

NCQA Health Plan Accreditation

NCQA accreditation evaluates how well a health plan manages all or parts of its delivery system—physicians, hospitals, other providers, and administrative services—in order to continuously improve health care for its members. A team of physicians and managed care experts conducts on-site and off-site evaluations. Among other things, these teams review grievance procedures, physician evaluation processes, care management processes, preventive health efforts, medical record keeping, quality improvement, and performance on key aspects of clinical care such as immunization rates.

A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the plan's performance compared to NCQA standards. A health plan must be aggressively managing quality and delivering excellent care and service to earn an accreditation rating of "Commendable" or "Excellent" from NCQA.

The standards and performance measures that make up NCQA's accreditation program fall into the following categories:

- **Access and Service** - Do health plan members have access to the care and service they need? For example: are doctors in the health plan free to discuss all treatment options available? Do patients report problems getting needed care? How well does the health plan follow up on grievances?
- **Qualified Providers** - Does the health plan assess each doctor's qualifications and what health plan members say about their providers? For example: does the health plan regularly check the licenses and training of physicians? How do health plan members rate their personal doctor or nurse?
- **Staying Healthy** - Does the health plan help people maintain good health and avoid illness? Does it give its doctors guidelines about how to provide appropriate preventive health services? Do members receive tests and screenings as appropriate?
- **Getting Better** - How well does the health plan care for people when they become sick? How does the health plan evaluate new medical procedures, drugs and devices to ensure that patients have access to safe and effective care?
- **Living with Illness** - How well does the health plan care for people with chronic conditions? Does the plan have programs in place to assist patients in managing chronic conditions like asthma? Do people with diabetes, who are at risk for blindness, receive eye exams as needed?

NCQA Accreditation Levels:

Excellent: NCQA's highest accreditation status is granted to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS results that are in the highest range of national or regional performance.

Commendable: This accreditation level is awarded to plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement. The "Commendable" designation is equivalent to NCQA's former designation of "Full Accreditation."

Accredited: Health plans that earn the "Accredited" designation must meet most of NCQA's basic requirements for consumer protection and quality improvement. "Accredited" is equivalent to the former designation of "One-Year."

Provisional: Provisional accreditation indicates that a health plan's service and clinical quality meet some, but not all of NCQA's basic requirements for consumer protection and quality improvement.

Denied: Denied is an indication that a health plan did not meet NCQA's requirements during its review.

Suspended: Denotes a plan in which circumstances have arisen to cause NCQA to withdraw accreditation, until such time as NCQA conducts a thorough investigation, and the plan completes corrective action.

***Under Review*:** Denotes a plan for which an initial accreditation determination has been made but is under review at the request of the plan.

NCQA Discretionary Review: Denotes a plan, which NCQA has chosen to review in order to assess the appropriateness of an existing accreditation decision.

HEDIS measures included in the NCQA Accreditation Program for 2002 are as follows:

- Adolescent Immunization Status
- Advising Smokers to Quit
- Antidepressant Medication Management (all three rates)
- Beta Blocker Treatment After a Heart Attack
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Cholesterol Management After Acute Cardiovascular Events (screening rate only)
- Comprehensive Diabetes Care (eye examination only)
- Follow-Up After Hospitalization for Mental Illness (30-day follow-up rate only)
- Prenatal and Postpartum Care-Timeliness of Prenatal Care
- Prenatal and Postpartum Care-Postpartum Care

CAHPS® 2.0H measures for the NCQA Accreditation Program for 2002 are as follows:

- Claims Processing
- Courteous and Helpful Office Staff
- Customer Service
- Getting Care Quickly

- Getting Needed Care
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Pharmacy Management Standards (MHCC-specific Performance Measures):

Maryland plans that are accredited by NCQA have met NCQA standards for pharmaceutical management, including formulary development. In order to help ensure that plan drug formularies are fair and valid, formulary policies are reviewed under the pharmaceutical management standards for managed care organizations that choose to be accredited by NCQA. NCQA standards require a plan to have the following:

- A formulary that is based on sound clinical evidence;
- An annual review of the formulary with updates at least annually;
- The involvement of appropriate, actively practicing practitioners, including pharmacists, in the development and updating of the formulary;
- A policy of giving practitioners a copy of the formulary and notifying them of changes;
- Exception policies that consider medically necessary exceptions to the formulary.

The following health plans are accredited by the NCQA and have met the pharmaceutical management standards described above:

Aetna	Kaiser
BlueChoice	M.D. IPA
CIGNA	OCI

JCAHO Health Plan Accreditation

JCAHO evaluates and accredits more than 17,000 health care organizations in the United States, including hospitals, health care networks, managed care organizations, and health care organizations that provide home care, long term care, behavioral health care, laboratory, and ambulatory care services. JCAHO standards address a health care organization's level of performance in specific areas. The standards set achievable performance expectations for activities that affect the quality of care.

JCAHO Accreditation Levels:

Accreditation with Full Standards Compliance (formerly Accreditation without Type I Recommendations): This accreditation status is awarded to a health care organization that

demonstrates satisfactory compliance with applicable JCAHO standards in all performance areas.

Accreditation with Requirements for Improvement (formerly Accreditation with Type I Recommendations): This accreditation level is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in most performance areas, but has deficiencies in one or more performance areas or in meeting accreditation policy requirements which require resolution within a specified time period.

***Provisional Accreditation*:** Awarded to a previously unaccredited health care organization that demonstrates satisfactory compliance with a subset of standards during a preliminary on-site evaluation. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later.

***Conditional Accreditation*:** Awarded to a health care organization that:

- fails to demonstrate compliance with applicable JCAHO standards in multiple performance areas; or
- is persistently unable or unwilling to demonstrate satisfactory compliance with one or more JCAHO standard(s); or
- fails to comply with one or more specified accreditation policy requirements, but is believed to be capable of achieving acceptable compliance within a stipulated time period.

***Preliminary Denial of Accreditation*:** Preliminary denial results when it is determined that there is justification to deny accreditation to a health care organization because the organization has failed to demonstrate satisfactory compliance with applicable JCAHO standards in multiple performance areas or accreditation policy requirements, or for other reasons. This accreditation decision is subject to subsequent review.

***Accreditation Denied*:** Accreditation denial results when a health care organization has been denied accreditation. This accreditation decision becomes effective only when all available appeal procedures have been exhausted.

***Accreditation with Commendation*:** This accreditation level was awarded to a health care organization that demonstrated more than satisfactory compliance with applicable JCAHO standards in all performance areas on a complete accreditation survey prior to January 1, 2000. Although this decision category has been discontinued effective January 1, 2000, organizations awarded this decision as a result of surveys conducted during 1998 and 1999 will retain this designation until their next complete surveys, unless it is lost based on an intracycle evaluation.

***Accreditation Watch*:** Though not a separate accreditation decision, accreditation watch is a publicly disclosed attribute of an organization's existing accreditation status. An organization is placed on Accreditation Watch when a sentinel event has occurred and a

thorough and credible root cause analysis of the sentinel event and an action plan have not been completed within a specified time frame. Following determination by JCAHO that the organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Accreditation Watch designation is removed from the organization's accreditation status. In Maryland, UnitedHealthcare (which has some commercial members, although the majority of members are covered by Medicaid) is accredited by JCAHO.

URAC Health Plan Accreditation

The URAC Health Plan Standards program is one of fourteen programs this organization has developed to promote quality health care delivery. It provides a full assessment of health plan performance covering network management, quality management and improvement, utilization management, provider credentialing, and member services. These standards apply to integrated health care systems such as HMOs or MBHOs, which offer a full range of services.

Organizations applying for accreditation participate in a review process that entails several phases. The initial phase consists of completing the application forms and supplying supporting documentation. The remaining phases of the accreditation process cover a period of approximately three to six months. These phases include the following:

Desktop Review: During the review process the reviewer conducts an analysis of the applicant's documentation in relation to the URAC standards. The application package consists of formal policies and procedures, organizational charts, position descriptions, contracts, sample template letters, and program descriptions and plans for departments such as quality management and credentialing. Any pending issues require clarification from the applicant.

Onsite Review: The accreditation review team conducts an onsite review after completing the desktop review to verify compliance with the standards. During this review, management is interviewed about the organization and staff observed performing its duties. Education and quality management programs are reviewed in detail. During the onsite visit, URAC reviewers also share "best practices" and provide other helpful guidance.

Authority to Grant Accreditation: The last phase of review leading to a recommendation regarding the application involves examination by two URAC committees comprised of professionals from health care and other industry experts. The URAC Accreditation Committee review process consists of a written summary documenting findings of the desktop and onsite reviews and discussion among members. An accreditation recommendation is then forwarded to URAC's Executive Committee, which has the authority to grant accreditation. After reviewing the summary and considering the Accreditation Committee's recommendation, the Executive Committee makes a final accreditation determination.

Conditions of Accreditation: Organizations awarded full accreditation must remain compliant with URAC standards during the two-year accreditation cycle. URAC has a grievance procedure for investigation of complaints about an accredited company. Complaints may originate from consumers, providers, or regulators. After completing the complaint investigation, URAC may sanction an accredited company. Sanctions range from a letter of reprimand to revocation of accreditation, depending on the nature and frequency of the violations.

URAC Accreditation Levels:

***Full*:** Granted to applicants successfully meeting all requirements. Organizations are awarded a full two-year accreditation, and an accreditation certificate is issued to each company site that participated in the accreditation review.

***Conditional*:** Granted to organizations that meet most of the standards, but need to improve certain policies or procedures before achieving full compliance. URAC requires organizations with Conditional Accreditation to follow a plan to demonstrate full compliance and move to Full Accreditation within six months.

Provisional: Granted to those organizations that have otherwise complied with all standards, but have not been in operation long enough (less than 12 months) to demonstrate full compliance with the standards.

Organizations that are unable to meet URAC standards may be placed on corrective action status, denied accreditation, or choose to withdraw.

B. MBHO ACCREDITATION

Like health plans, MBHOs can apply for voluntary accreditation. Accreditation indicates that the MBHO has met the quality standards set by the accrediting organization. Maryland plans that reported to the State in 2002 are accredited by NCQA and URAC (American Accreditation Healthcare Commission). JACHO also accredits MBHOs.

The following table shows which plans use MBHOs to cover some or all of their members. The table also indicates which MBHOs have been accredited, by which accrediting organization, and when current accreditation expires.

Three MBHOs are accredited by URAC, one MBHO is accredited by NCQA, and three plans provide some or all of their own behavioral health services that are not accredited separately from the health plan's accreditation.

Health Plan	Name of MBHO(s)	Is MBHO Fully Accredited?	Name of Accrediting Body	Accreditation Valid Through***
Aetna	Magellan Behavioral Health	Yes	URAC	Summer 2002 Review
BlueChoice	Magellan Behavioral Health	Yes	URAC	Summer 2002 Review
	Value Options	Yes	URAC	March 2003
CIGNA	CIGNA Behavioral Health	Yes	URAC	December 2003
Coventry	APS Healthcare, Inc.	Yes	NCQA	May 2004
Delmarva	Magellan Behavioral Health	Yes	URAC	Summer 2002 Review
Kaiser*	KPMAS *	NA**	NA**	NA**
	APS Healthcare, Inc.	Yes	NCQA	May 2004
M.D. IPA**	NA-provided within M.D. IPA	NA**	NA**	NA**
OCI**	NA-provided within OCI	NA**	NA**	NA**
PHN	APS Healthcare, Inc.	Yes	NCQA	May 2004

*Kaiser contracted with two MBHOs in 2001, Magellan and Sheppard Pratt (In calendar 2002, Kaiser (KPMAS) provided services outside the Baltimore area and APS Healthcare, Inc. provided services to members in Baltimore.
**Accredited health plan providing behavioral health services directly.
***Accreditation Status as of August 5, 2002.

NCQA – National Committee for Quality Assurance
URAC – URAC/American Accreditation Healthcare Commission

URAC MBHO Accreditation

MBHOs, like other integrated health care delivery systems, may choose to undergo a full review of their operations or have individual components reviewed for accreditation. URAC's Health Plan Standards program assesses and organization and assigns an accreditation level based on its performance as compared to the defined standards. This process consists of the same multi-phase review described in the previous section for Health Plan Accreditation. A range of accreditation programs is available through URAC that permit a review of a segment of the operations. The Health Utilization Management Standards is an example of an accreditation module managed care organizations, such as MBHOs, select to demonstrate they have the appropriate structures and procedures to promote quality care when making medical necessity determinations.

NCQA MBHO Accreditation

NCQA's Managed Behavioral Healthcare Organization (MBHO) Accreditation program was launched in 1996. Since then, NCQA's MCO and MBHO Accreditation programs have become closely aligned, with nearly identical sets of standards applying to both types of organizations. Both accreditation programs seek to promote access to behavioral health care and coordination between medical and behavioral health professionals. NCQA's MBHO Accreditation program is designed to:

- Foster accountability among MBHOs for the quality of care and service their members receive,
- Provide employers, public purchasers, plans and consumers with meaningful information regarding MBHOs, and
- Encourage effectiveness in the provision of behavioral health care by addressing the need for prevention, early intervention and coordination of behavioral health with medical care.

In NCQA's MBHO Accreditation Program, Standard PH 4 requires that an MBHO annually monitor and evaluate at least two of the preventive behavioral health screening and educational interventions offered to its covered population. The categories of preventive interventions listed in PH 4 are adapted from the Institute of Medicine's *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research,* 1994. This publication lists a number of illustrative preventive interventions for the various age and population categories.

NCQA Accreditation Levels:

***Full*:** The MBHO has excellent programs for quality improvement and consumer protection and meets or exceeds NCQA's standards. Full accreditation is effective for a three-year period.

***One Year*:** The MBHO has well-established programs for quality improvement and consumer protection and meets most NCQA standards. NCQA has given the MBHO a list of recommendations and will review the organization again after a year to determine if it qualifies for Full Accreditation.

***Provisional*:** The MBHO has adequate programs for quality improvement and consumer protection and meets some of NCQA's standards. NCQA has given the MBGHO a list of recommendations and will review the organization again after a year to determine if it qualifies for a higher level of accreditation.

***Denied*:** Denied is an indication that the MBHO did not meet NCQA's requirements during its review.

***Appealed by MBHO*:** Indicates an initial accreditation outcome is under review at the request of the MBHO.

***Under Review by NCQA*:** Indicates NCQA has chosen to re-review the MBHO in order to assess the appropriateness of an existing accreditation outcome.

***In Process*:** Indicates NCQA has reviewed the MBHO for the first time and is in the process of making a decision on the accreditation outcome.

***Scheduled*:** Indicates the MBHO is on NCQA's schedule for an initial accreditation review.

JCAHO MBHO Accreditation

The Joint Commission on the Accreditation of Healthcare Organizations' (JCAHO) accredits health care organizations throughout the United States, including MBHOs. JCAHO standards for accrediting MBHOs are similar to those for health plans; they address an organization's level of performance in specific areas.

JCAHO Accreditation Levels:

JCAHO has eight accreditation decision categories.

Accreditation with Full Standards Compliance (formerly Accreditation without Type I Recommendations): This accreditation status is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in all performance areas.

Accreditation with Requirements for Improvement (formerly Accreditation with Type I Recommendations): This accreditation level is awarded to a health care organization that demonstrates satisfactory compliance with applicable JCAHO standards in most performance areas, but has deficiencies in one or more performance areas or accreditation policy requirements that require resolution within a specified time period.

***Provisional Accreditation*:** An accreditation decision that results when a health care organization demonstrates satisfactory compliance with a subset of standards during a preliminary on-site evaluation. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later. This accreditation level is awarded to previously unaccredited health care organization.

***Conditional Accreditation*:** This accreditation level is awarded to a health care organization that:

- fails to demonstrate compliance with applicable JCAHO standards in multiple performance areas, or but is believed to be capable of achieving acceptable standards compliance within a stipulated time period;
- is persistently unable or unwilling to demonstrate compliance with one or more JCAHO standard(s); or,
- fails to comply with one or more specified accreditation policy requirements, but is believed to be capable of achieving acceptable compliance within a stipulated time period.

***Preliminary Denial of Accreditation*:** Effective January 1, 2001 Preliminary Denial of Accreditation (previously Preliminary Nonaccreditation), results when it is determined that there is justification to deny accreditation to a health care organization because the organization has failed to demonstrate satisfactory compliance with applicable JCAHO standards in multiple performance areas, or accreditation policy requirements, or for other reasons. This accreditation decision is subject to subsequent review.

***Accreditation Denied*:** Effective January 1, 2001 Accreditation Denied (previously Not Accredited), results when a health care organization has been denied accreditation. This accreditation decision becomes effective only when all available appeal procedures have been exhausted.

***Accreditation with Commendation*:** Accreditation with Commendation, (eliminated, effective January 1, 2000), was awarded to a health care organization that demonstrated more than satisfactory compliance with applicable JCAHO standards in all performance areas on a complete accreditation survey. Although this decision category has been discontinued as of January 1, 2000, organizations awarded this decision as a result of surveys conducted during 1997, 1998 and 1999 will retain this designation until their next complete surveys, unless it is lost based on an intracycle evaluation.

***Accreditation Watch*:** Accreditation Watch, (though not a separate accreditation decision), is a publicly disclosed attribute of an organization's existing accreditation status. An organization is placed on Accreditation Watch when a sentinel event has occurred and a thorough and credible root cause analysis of the sentinel event and an action plan have not been completed within a specified time frame. Following determination by JCAHO that the organization has conducted an acceptable root cause analysis and developed an acceptable action plan, the Accreditation Watch designation is removed from the organization's accreditation status.

C. A.M. BEST RATINGS

A.M. Best's financial strength ratings provide an independent opinion on the health insurance organization's ability to meet its obligations to its membership through an evaluation of its balance sheet strength, operating performance, and business profile. Information on plan financial strength from A.M. Best will help purchasers and consumers make more informed health care purchasing decisions.

At the HMO or insurance company's request, and with compensation by the company they reviews, A.M. Best analysts review detailed financial statements, interview senior management; analyze data and information leading to an assignment of a financial strength rating following a committee review process. All health insurance companies are formally evaluated once every 12 months and they are subject to review following any significant event (e.g., unexpected changes to earnings or capital, management and changes in ownership).

Ratings may also be conducted on a non-interactive basis. In those instances, A.M. Best assigns the rating based on a comprehensive review of the regulatory filings, publicly available data, and other public information. This type of rating is denoted as Public Data (pd). Public Data (pd) ratings incorporate analysis of balance sheet strength, operating performance and business profile; however, the analysis does not generally involve interaction with company management.

The Best's Rating scale is comprised of 16 individual ratings, grouped into 10 categories, consisting of three **Secure** categories of "Superior," "Excellent," and "Very Good," and seven **Vulnerable** categories of "Fair," "Marginal," "Weak," "Poor," "Under Regulatory Supervision," "In Liquidation," and "Rating Suspended."

Secure ratings indicate an insurer has a strong or good ability to meet its obligations to members and policyholders; it maintains a level of financial strength that can withstand unfavorable changes in the business, economic, or regulatory environment. Vulnerable ratings tend to present progressively higher risks, moving from Fair to Poor.

For non-rated (NR) companies, a condition exists that makes it difficult for A.M. Best to develop an opinion on the company's balance sheet strength and operating performance. Generally, these companies do not qualify for a Best's Rating because of limited financial information, small level of surplus, lack of sufficient operating experience, or due to their dormant or run-off status. Generally, NR companies carry greater risk of insolvency.

Definitions of Best's Ratings, and Not Rated Categories (NR)

Secure Best's Ratings:

- ***A++ and A+ (Superior)*:** Assigned to companies that have, in A.M. Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

- ***A and A- (Excellent):*** Assigned to companies that have, in A.M. Best's opinion, an excellent ability to meet their ongoing obligations to policyholders.

- ***B++ and B+ (Very Good):*** Assigned to companies that have, in A.M. Best's opinion, a good ability to meet their ongoing obligations to policyholders.

Vulnerable Best's Ratings:

- ***B and B- (Fair):*** Assigned to companies that have, in A.M. Best's opinion, a fair ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

- ***C++ and C+ (Marginal):*** Assigned to companies that have, in A.M. Best's opinion, a marginal ability to meet their current obligations to policyholders, but are financially vulnerable to adverse changes in underwriting and economic conditions.

- ***C and C- (Weak):*** Assigned to companies that have, in A.M. Best's opinion, a weak ability to meet their current obligations to policyholders, but are financially very vulnerable to adverse changes in underwriting and economic conditions.

- ***D (Poor):*** Assigned to companies that in A.M. Best's opinion, may not have an ability to meet their current obligations to policyholders and are financially extremely vulnerable to adverse changes in underwriting and economic conditions.

- ***E (Under Regulatory Supervision):*** Assigned to companies (and possibly their subsidiaries/affiliates) that have been placed by an insurance regulatory authority under a significant form of supervision, control or restraint whereby they are no longer allowed to conduct normal ongoing insurance operations. This would include conservatorship or rehabilitation, but does not include liquidation. It may also be assigned to companies issued cease and desist orders by regulators outside their home state or country.

- ***F (In Liquidation):*** Assigned to companies that have been placed under an order of liquidation by a court of law or whose owners have voluntarily agreed to liquidate the company. Note: Companies that voluntarily liquidate or dissolve their charters are generally not insolvent.

- ***S (Rating Suspended):*** Assigned to rated companies that have experienced sudden and significant events affecting their balance sheet strength or operating performance whose rating implications cannot be evaluated due to a lack of timely or adequate information.

Maryland Commercial HMO/POS	A.M. Best Financial Rating*
Aetna	A- Excellent (A.M. Best ID# 68550)
BlueChoice	B+ Very Good; pd (A.M. Best ID# 68605)
CIGNA	A- Excellent (A.M. Best ID# 68871)
Coventry	B Fair; pd (A.M. Best ID# 68687)
Delmarva	C++ Marginal; pd (A.M. Best ID# 68756)
Kaiser.	B Fair; pd (A.M. Best ID# 68551)
M.D. IPA	B Fair; pd (A.M. Best ID# 68606)
OCI	B Fair; pd (A.M. Best ID# 68764)
PHN	C Weak; pd (A.M. Best ID#64295)

*A.M. Best Financial Rating as of August 5, 2002.

Delmarva, M.D. IPA, and OCI were ech downgraded from their previous A.M. Best Ratings of B- Fair, B+ Very Good, and B+ Very Good, respectively. PHN was upgraded from D Poor.

APPENDIX A

HEALTH PLAN PERFORMANCE BY MEASURE

Table 99: Star Performers by Plan

Plan	Number of Star Performer Designations	Measures for which Plan Achieved Star Performer Status
BlueChoice	1	Well-Child Visits for Infants and Children
Coventry	3	Getting Needed Care Rating of Health Care Received Well-Child Visits for Infants and Children
Delmarva	8	How Members Rate Their Health Plan Few Consumer Complaints Health Plan Customer Service Getting Needed Care Getting Care Quickly How Often Doctors Communicated Well Rating of Health Care Received Comprehensive Diabetes Care: Cholesterol Testing
Kaiser	6	Few Consumer Complaints Health Plan Customer Service Immunizations for Children (Combination 2) Comprehensive Diabetes Care: Eye Exams Beta Blocker Treatment After a Heart Attack Follow-Up After Hospital Discharge (30 Days)
M.D. IPA	6	Health Plan Customer Service Immunizations for Children (Combination 2) Well-Child Visits for Infants and Children Well-Care Visits for Adolescents Check-Ups For New Moms Controlling High Blood Pressure
OCI	1	Few Consumer Complaints
PHN	1	Well-Child Visits for Infants and Children

Note: Measure names used in the above table correspond to those used in the *Consumer Guide*. Measure names used elsewhere in the *Comprehensive Report* correspond to those used in HEDIS Technical Specifications.

Table 100: Total Above Average Scores by Plan

Total Above Average Scores by Plan								
	Effectiveness of Care	Access/ Availability	HP Stability	Use of Services	HP Descriptive Info	Total HEDIS	Total CAHPS	Total HEDIS and CAHPS
Total Number of Measures in Each Domain:	**24**	**6**	**1**	**2**	**8**	**41**	**9**	**50**
Aetna	5	2	0	0	4	11	0	11
BlueChoice	2	1	1	1	0	5	0	5
CIGNA	5	1	0	0	4	10	0	10
Coventry	8	3	1	1	7	20	2	22
Delmarva	7	5	0	0	3	15	8	23
Kaiser	16	5	0	0	3	24	4	28
M.D. IPA	5	2	0	2	4	13	4	17
OCI	3	0	0	1	4	8	1	9
PHN	0	3	0	2	8	13	0	13

For each plan, the table shows the total number of measures in each domain for which the plan had an "above average" relative rate in 2002. All measures for which relative rates were generated were included in calculation, except for: 1) relative scores for individual vaccines in the Childhood and Adolescent Immunization measures and 2) relative scores by age category for relevant measures (i.e., the chlamydia, asthma and well-child measures). The total number of measures in each domain for which relative rates were considered appears in the bottom row of the table.

The following measures were included in each domain:

Effectiveness of Care: Childhood Immunization Status (Combos 1&2), Adolescent Immunization Status (Combos 1&2), Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women (Total), Controlling High Blood Pressure, Beta Blocker After Heart Attack, Cholesterol Management After Acute Cardiovascular Events (Cholesterol Screening & Cholesterol Level), Comprehensive Diabetes Care (Blood Glucose Testing, Blood Glucose Control, Eye Exams, Cholesterol Testing, Cholesterol Control, Monitoring Diabetic Nephropathy), Use of Appropriate Medications for People with Asthma (all ages combined), Follow-Up After Hospitalization for Mental Illness (7 Days & 30 Days), Antidepressant Medication Management (Contacts, Acute, Continuation), Flu Shots for Adults Age 50-64

Access/Availability: Adults' Access to Preventative/Ambulatory Health Services (Ages 20-64), Children's Access to Primary Care Providers (12-24 Months & 25 Months - 6 Years & 7-11 Years), Prenatal and Postpartum Care (Prenatal & Postpartum)

HP Stability: Practitioner Turnover

Use of Services: Well-Child (Composite), Adolescent Well-Care Visits

HP Descriptive Info: Board Certification (PCP, OB/GYN, Pediatrician, Other Specialists), Residency Completion (PCP, OB/GYN, Pediatrician, Other)

Total CAHPS®: How Members Rate Their Health Plan, Recommending Plan to Friends/Family, Few Consumer Complaints, Helpfulness of Information Provided by Plan, Health Plan Customer Service, Getting Needed Care, Getting Care Quickly, How Often Doctors Communicated Well, Rating Health Care Received

Effectiveness of Care Measures
Plan Performance by Measure

Childhood Immunization Status Combination 1 2002 Results		
	2002	
Maryland HMO/POS Average	71%	
Kaiser	82%	●
Coventry	81%	●
M.D. IPA	76%	●
CIGNA	75%	⊙
OCI	75%	⊙
Aetna	74%	⊙
BlueChoice	69%	⊙
PHN	59%	○
Delmarva	50%	○

Childhood Immunization Status Combination 2 2002 Results		
	2002	
Maryland HMO/POS Average	66%	
Kaiser	79%	●
M.D. IPA	72%	●
OCI	71%	●
Coventry	70%	●
CIGNA	70%	●
Aetna	69%	⊙
BlueChoice	65%	⊙
Delmarva	49%	○
PHN	48%	○

Childhood Immunization Status - DTP 2002 Results		
	2002	
Maryland HMO/POS Average	85%	
Coventry	89%	●
Kaiser	87%	●
Delmarva	90%	⊙
M.D. IPA	88%	⊙
OCI	85%	⊙
Aetna	85%	⊙
CIGNA	83%	⊙
BlueChoice	81%	○
PHN	80%	○

Childhood Immunization Status - OPV 2002 Results		
	2002	
Maryland HMO/POS Average	90%	
Coventry	93%	●
M.D. IPA	93%	●
Delmarva	93%	⊙
PHN	90%	⊙
OCI	90%	⊙
Kaiser	90%	⊙
Aetna	89%	⊙
CIGNA	87%	⊙
BlueChoice	84%	○

Childhood Immunization Status - MMR 2002 Results		
	2002	
Maryland HMO/POS Average	92%	
Coventry	95%	●
Delmarva	94%	⊙
OCI	93%	⊙
M.D. IPA	93%	⊙
CIGNA	93%	⊙
Aetna	91%	⊙
Kaiser	91%	⊙
BlueChoice	90%	⊙
PHN	84%	○

Childhood Immunization Status - HIB 2002 Results		
	2002	
Maryland HMO/POS Average	87%	
Coventry	92%	●
Kaiser	91%	●
M.D. IPA	90%	●
OCI	89%	⊙
Aetna	88%	⊙
CIGNA	87%	⊙
PHN	83%	○
BlueChoice	82%	○
Delmarva	78%	○

Effectiveness of Care Measures
Plan Performance by Measure

Childhood Immunization Status - Hep B 2002 Results		
	2002	
Maryland HMO/POS Average	82%	
Coventry	90%	●
Kaiser	88%	●
CIGNA	87%	●
Aetna	85%	●
M.D. IPA	85%	●
OCI	84%	⊙
BlueChoice	80%	⊙
PHN	72%	○
Delmarva	65%	○

Childhood Immunization Status - VZV 2002 Results		
	2002	
Maryland HMO/POS Average	86%	
Delmarva	93%	●
OCI	89%	●
Kaiser	87%	●
CIGNA	89%	⊙
M.D. IPA	88%	⊙
Aetna	87%	⊙
Coventry	83%	⊙
BlueChoice	82%	⊙
PHN	74%	○

Adolescent Immunization Status Combination 1 2002 Results		
	2002	
Maryland HMO/POS Average	44%	
Coventry	75%	●
Delmarva	51%	●
Kaiser	51%	●
BlueChoice	43%	⊙
M.D. IPA	43%	⊙
CIGNA	39%	○
Aetna	38%	○
OCI	35%	○
PHN	24%	○

Adolescent Immunization Status Combination 2 2002 Results		
	2002	
Maryland HMO/POS Average	27%	
Coventry	38%	●
Kaiser	35%	●
M.D. IPA	28%	⊙
Delmarva	28%	⊙
BlueChoice	28%	⊙
CIGNA	25%	⊙
Aetna	24%	⊙
OCI	22%	○
PHN	15%	○

Adolescent Immunization Status - MMR 2002 Results		
	2002	
Maryland HMO/POS Average	73%	
Coventry	87%	●
Delmarva	84%	●
M.D. IPA	80%	●
Kaiser	73%	⊙
OCI	72%	⊙
BlueChoice	71%	⊙
CIGNA	70%	⊙
Aetna	69%	○
PHN	54%	○

Adolescent Immunization Status - Hep B 2002 Results		
	2002	
Maryland HMO/POS Average	48%	
Coventry	78%	●
Kaiser	54%	●
Delmarva	54%	⊙
M.D. IPA	46%	⊙
BlueChoice	46%	⊙
CIGNA	41%	○
Aetna	41%	○
OCI	37%	○
PHN	33%	○

Effectiveness of Care Measures
Plan Performance by Measure

Adolescent Immunization Status - VZV/VAR 2002 Results		
	2002	
Maryland HMO/POS Average	41%	
Kaiser	48%	●
M.D. IPA	45%	⊙
CIGNA	43%	⊙
BlueChoice	43%	⊙
Coventry	41%	⊙
Delmarva	41%	⊙
OCI	40%	⊙
Aetna	38%	⊙
PHN	28%	○

Breast Cancer Screening 2002 Results		
	2002	
Maryland HMO/POS Average	76%	
Coventry	84%	●
BlueChoice	79%	⊙
Delmarva	78%	⊙
Kaiser	76%	⊙
CIGNA	76%	⊙
M.D. IPA	74%	⊙
OCI	73%	⊙
Aetna	73%	⊙
PHN	72%	⊙

Cervical Cancer Screening 2002 Results		
	2002	
Maryland HMO/POS Average	83%	
Kaiser	87%	●
M.D. IPA	84%	⊙
CIGNA	83%	⊙
PHN	82%	⊙
OCI	82%	⊙
Aetna	82%	⊙
BlueChoice	81%	⊙
Coventry	78%	⊙
Delmarva	77%	○

Chlamydia Screening Total 2002 Results		
	2002	
Maryland HMO/POS Average	29%	
Kaiser	77%	●
Coventry	34%	●
CIGNA	30%	⊙
Delmarva	28%	⊙
BlueChoice	26%	○
OCI	20%	○
M.D. IPA	19%	○
PHN	17%	○
Aetna	13%	○

Controlling High Blood Pressure 2002 Results		
	2002	
Maryland HMO/POS Average	53%	
CIGNA	71%	●
Aetna	63%	●
Delmarva	62%	●
M.D. IPA	60%	●
OCI	57%	⊙
Coventry	54%	⊙
BlueChoice	54%	⊙
Kaiser	51%	⊙
PHN	5%	○

Beta Blocker After Heart Attack 2002 Results		
	2002	
Maryland HMO/POS Average	92%	
Kaiser	100%	●
Aetna	98%	●
CIGNA	96%	⊙
OCI	90%	⊙
M.D. IPA	90%	⊙
Coventry	90%	⊙
BlueChoice	83%	○
Delmarva	NA	NA
PHN	NA	NA

Effectiveness of Care Measures
Plan Performance by Measure

Cholesterol Management Cholesterol (LDL-C) Screening, 2002 Results		
	2002	
Maryland HMO/POS Average	**74%**	
OCI	81%	●
Aetna	79%	●
CIGNA	78%	⊙
M.D. IPA	77%	⊙
Kaiser	77%	⊙
Delmarva	71%	⊙
BlueChoice	70%	⊙
Coventry	68%	⊙
PHN	64%	○

Cholesterol Management Cholesterol (LDL-C) Control, 2002 Results		
	2002	
Maryland HMO/POS Average	**57%**	
Kaiser	73%	●
CIGNA	63%	●
M.D. IPA	62%	⊙
Delmarva	61%	⊙
OCI	58%	⊙
Aetna	57%	⊙
BlueChoice	56%	⊙
Coventry	55%	⊙
PHN	25%	○

Comprehensive Diabetes Care Blood Glucose (HbA1c) Testing, 2002 Results		
	2002	
Maryland HMO/POS Average	**81%**	
Delmarva	85%	●
Kaiser	85%	●
CIGNA	84%	⊙
Aetna	83%	⊙
BlueChoice	83%	⊙
M.D. IPA	82%	⊙
OCI	82%	⊙
Coventry	80%	⊙
PHN	70%	○

Comprehensive Diabetes Care Blood Glucose (HbA1c) Control, 2002 Results		
	2002	
Maryland HMO/POS Average	**61%**	
Delmarva	76%	●
BlueChoice	71%	●
M.D. IPA	68%	●
OCI	66%	●
CIGNA	66%	●
Coventry	64%	⊙
Kaiser	64%	⊙
Aetna	60%	⊙
PHN	15%	○

Comprehensive Diabetes Care Eye Exams, 2002 Results		
	2002	
Maryland HMO/POS Average	**50%**	
Kaiser	76%	●
Coventry	58%	●
BlueChoice	53%	⊙
Aetna	51%	⊙
M.D. IPA	47%	⊙
OCI	45%	○
Delmarva	44%	○
CIGNA	41%	○
PHN	38%	○

Comprehensive Diabetes Care Cholesterol Testing, 2002 Results		
	2002	
Maryland HMO/POS Average	**83%**	
Delmarva	88%	●
CIGNA	87%	●
OCI	86%	⊙
Kaiser	85%	⊙
M.D. IPA	84%	⊙
BlueChoice	83%	⊙
Coventry	82%	⊙
Aetna	80%	⊙
PHN	75%	○

Effectiveness of Care Measures
Plan Performance by Measure

Comprehensive Diabetes Care Cholesterol Control, 2002 Results		
	2002	
Maryland HMO/POS Average	**52%**	
Delmarva	70%	●
Kaiser	64%	●
BlueChoice	59%	●
CIGNA	56%	⊙
M.D. IPA	55%	⊙
OCI	51%	⊙
Coventry	48%	⊙
Aetna	48%	⊙
PHN	18%	○

Comprehensive Diabetes Care Monitoring Diabetic Nephropathy, 2002 Results		
	2002	
Maryland HMO/POS Average	**47%**	
Kaiser	78%	●
Delmarva	66%	●
Coventry	57%	●
Aetna	50%	⊙
CIGNA	44%	⊙
M.D. IPA	36%	○
OCI	34%	○
PHN	34%	○
BlueChoice	28%	○

Medications Used for Asthma Combined Age Groups, 2002 Results		
	2002	
Maryland HMO/POS Average	**63%**	
Kaiser	72%	●
Aetna	66%	●
CIGNA	66%	⊙
Delmarva	65%	⊙
Coventry	64%	⊙
PHN	58%	○
M.D. IPA	57%	○
OCI	54%	○
BlueChoice	NR	NR

Follow-up After Hospitalization for Mental Illness, 7 Days, 2002 Results		
	2002	
Maryland HMO/POS Average	**52%**	
Kaiser	69%	●
M.D. IPA	59%	●
Aetna	58%	●
Delmarva	60%	⊙
CIGNA	56%	⊙
OCI	51%	⊙
Coventry	45%	○
BlueChoice	20%	○
PHN	NA	NA

Follow-up After Hospitalization for Mental Illness, 30 Days, 2002 Results		
	2002	
Maryland HMO/POS Average	**76%**	
Kaiser	80%	●
Aetna	79%	⊙
Delmarva	77%	⊙
M.D. IPA	75%	⊙
OCI	75%	⊙
BlueChoice	75%	⊙
Coventry	73%	⊙
CIGNA	70%	⊙
PHN	NA	NA

Antidepressant Medication Management, Optimal Practitioner Contacts, 2002 Results		
	2002	
Maryland HMO/POS Average	**21%**	
M.D. IPA	31%	●
OCI	29%	●
Coventry	27%	⊙
Aetna	21%	⊙
CIGNA	17%	⊙
BlueChoice	16%	○
Kaiser	16%	○
Delmarva	10%	○
PHN	NA	NA

Effectiveness of Care Measures
Plan Performance by Measure

Antidepressant Medication Management, Effective Acute Phase Treatment, 2002 Results		
	2002	
Maryland HMO/POS Average	**59%**	
Kaiser	63%	●
Delmarva	66%	⊙
Coventry	59%	⊙
M.D. IPA	58%	⊙
BlueChoice	58%	⊙
Aetna	57%	⊙
OCI	56%	⊙
CIGNA	55%	⊙
PHN	NA	NA

Antidepressant Medication Management, Effective Continuation Phase, 2002 Results		
	2002	
Maryland HMO/POS Average	**39%**	
Kaiser	46%	●
Delmarva	45%	⊙
Coventry	41%	⊙
Aetna	40%	⊙
OCI	37%	⊙
M.D. IPA	36%	⊙
CIGNA	32%	○
BlueChoice	32%	○
PHN	NA	NA

Flu Shots for Adults 50-64 2002 Results		
	2002	
Maryland HMO/POS Average	**46%**	
Kaiser	57%	●
M.D. IPA	51%	⊙
Coventry	50%	⊙
PHN	47%	⊙
Delmarva	46%	⊙
BlueChoice	44%	○
OCI	41%	⊙
Aetna	41%	⊙
CIGNA	36%	¤

Access and Availability Measures
Plan Performance by Measure

Adults' Access to Preventive/Ambulatory Health Services (Ages 20-64), 2002 Results		
	2002	
Maryland HMO/POS Average	93%	
Kaiser	95%	●
Delmarva	94%	●
PHN	94%	●
Coventry	94%	●
M.D. IPA	94%	●
OCI	93%	○
Aetna	92%	○
BlueChoice	91%	○
CIGNA	90%	○

Children's Access to Primary Care Providers (12-24 Months), 2002 Results		
	2002	
Maryland HMO/POS Average	97%	
Delmarva	99%	●
Kaiser	99%	●
PHN	98%	⊙
M.D. IPA	98%	⊙
Coventry	97%	⊙
OCI	97%	⊙
Aetna	96%	○
BlueChoice	95%	○
CIGNA	94%	○

Children's Access to Primary Care Providers (25 Months-6 Years), 2002 Results		
	2002	
Maryland HMO/POS Average	89%	
Kaiser	97%	●
Coventry	92%	●
Delmarva	91%	●
PHN	91%	●
BlueChoice	88%	○
M.D. IPA	87%	○
OCI	87%	○
CIGNA	85%	○
Aetna	84%	○

Children's Access to Primary Care Providers (7-11 Years), 2002 Results		
	2002	
Maryland HMO/POS Average	89%	
Kaiser	95%	●
Delmarva	93%	●
PHN	92%	●
Coventry	92%	●
BlueChoice	88%	⊙
M.D. IPA	87%	○
OCI	86%	○
CIGNA	83%	○
Aetna	82%	○

Prenatal and Postpartum Care, Prenatal 2002 Results		
	2002	
Maryland HMO/POS Average	85%	
Delmarva	92%	●
Aetna	92%	●
CIGNA	91%	●
Kaiser	89%	●
BlueChoice	89%	●
M.D. IPA	88%	⊙
OCI	87%	⊙
Coventry	80%	○
PHN	57%	○

Prenatal and Postpartum Care, Postpartum 2002 Results		
	2002	
Maryland HMO/POS Average	78%	
Aetna	84%	●
M.D. IPA	82%	●
Delmarva	82%	⊙
CIGNA	81%	⊙
OCI	81%	⊙
Kaiser	81%	⊙
BlueChoice	77%	⊙
Coventry	73%	○
PHN	60%	○

Satisfaction with the Experience Measures
Plan Performance by Measure

How Members Rate Their Health Plan 2002 Results				
	Rating 0-6	Rating 7-8	Rating 9-10	2002 Category
Maryland HMO/POS Average	**22%**	**40%**	**37%**	
Delmarva	12%	36%	52%	●
Coventry	17%	35%	48%	●
M.D. IPA	18%	41%	41%	⊙
OCI	24%	39%	38%	⊙
Kaiser	21%	45%	34%	⊙
Aetna	28%	40%	33%	○
BlueChoice	26%	42%	31%	○
CIGNA	28%	42%	29%	○
PHN	28%	43%	29%	○

Recommending Plan to Friends/Family 2002 Results					
	Definitely Not	Probably Not	Probably Yes	Definitely Yes	2002 Category
Maryland HMO/POS Average	**4%**	**10%**	**52%**	**34%**	
M.D. IPA	2%	7%	46%	45%	●
Kaiser	4%	10%	46%	40%	●
Delmarva	3%	7%	51%	40%	●
Coventry	2%	7%	52%	39%	⊙
BlueChoice	4%	10%	55%	30%	⊙
OCI	3%	10%	57%	30%	⊙
CIGNA	6%	13%	52%	29%	○
PHN	4%	12%	55%	28%	○
Aetna	5%	14%	53%	27%	○

Satisfaction with the Experience Measures
Plan Performance by Measure

Few Consumer Complaints 2002 Results			
	No	Yes	2002 Category
Maryland HMO/POS Average	**83%**	**17%**	
Delmarva	89%	11%	●
Kaiser	88%	12%	●
OCI	86%	14%	●
M.D. IPA	83%	17%	⊙
CIGNA	82%	18%	⊙
PHN	82%	18%	⊙
Aetna	81%	19%	⊙
BlueChoice	77%	23%	○
Coventry	77%	23%	○

Helpfulness of Information Provided by Plan 2002 Results					
	Did Not Receive	Sometimes/ Never	Usually	Always	2002 Category
Maryland HMO/POS Average	**16%**	**23%**	**31%**	**30%**	
M.D. IPA	11%	17%	36%	36%	●
Kaiser	13%	24%	29%	34%	●
Aetna	12%	24%	30%	33%	⊙
Delmarva	16%	20%	31%	32%	⊙
OCI	15%	22%	33%	30%	⊙
Coventry	23%	19%	28%	29%	⊙
CIGNA	16%	26%	30%	28%	⊙
PHN	13%	30%	31%	25%	○
BlueChoice	23%	28%	29%	20%	○

Satisfaction with the Experience Measures
Plan Performance by Measure

Health Plan Customer Service 2002 Results				
	Big Problem	Small Problem	Not a Problem	2002 Category
Maryland HMO/POS Average	**10%**	**22%**	**68%**	
Delmarva	5%	19%	76%	●
Kaiser	7%	17%	76%	●
M.D. IPA	6%	19%	75%	●
OCI	7%	24%	69%	⊙
Aetna	11%	21%	68%	⊙
CIGNA	14%	20%	66%	⊙
Coventry	10%	25%	66%	⊙
PHN	14%	27%	60%	○
BlueChoice	15%	28%	57%	○

Getting Needed Care 2002 Results				
	Big Problem	Small Problem	Not a Problem	2002 Category
Maryland HMO/POS Average	**7%**	**17%**	**77%**	
Delmarva	5%	11%	84%	●
Coventry	6%	13%	81%	●
M.D. IPA	4%	17%	79%	⊙
Aetna	7%	16%	77%	⊙
OCI	5%	19%	75%	⊙
Kaiser	8%	17%	75%	⊙
PHN	8%	18%	74%	⊙
CIGNA	8%	19%	73%	○
BlueChoice	7%	20%	73%	○

Satisfaction with the Experience Measures
Plan Performance by Measure

Getting Care Quickly 2002 Results				
	Sometimes/ Never	Usually	Always	2002 Category
Maryland HMO/POS Average	**22%**	**36%**	**42%**	
Delmarva	18%	32%	50%	●
M.D. IPA	20%	33%	47%	●
Coventry	19%	37%	45%	⊙
PHN	21%	37%	42%	⊙
OCI	22%	37%	41%	⊙
Kaiser	23%	36%	41%	⊙
Aetna	25%	35%	40%	⊙
BlueChoice	26%	35%	39%	⊙
CIGNA	25%	38%	37%	○

How Often Doctors Communicated Well 2002 Results				
	Sometimes/ Never	Usually	Always	2002 Category
Maryland HMO/POS Average	**11%**	**33%**	**56%**	
Delmarva	7%	28%	66%	●
M.D. IPA	9%	32%	59%	⊙
Coventry	8%	34%	58%	⊙
PHN	10%	32%	58%	⊙
Aetna	11%	32%	57%	⊙
OCI	13%	34%	53%	⊙
CIGNA	11%	36%	53%	⊙
BlueChoice	12%	36%	52%	○
Kaiser	16%	34%	50%	○

Satisfaction with the Experience Measures
Plan Performance by Measure

Rating of Health Care Received 2002 Results				
	Rating 0-6	Rating 7-8	Rating 9-10	2002 Category
Maryland HMO/POS Average	**15%**	**39%**	**46%**	
Delmarva	10%	34%	56%	●
Coventry	11%	35%	54%	●
M.D. IPA	12%	40%	48%	⊙
Aetna	18%	36%	46%	⊙
BlueChoice	16%	39%	45%	⊙
OCI	15%	41%	45%	⊙
PHN	15%	41%	44%	⊙
CIGNA	14%	47%	39%	○
Kaiser	20%	42%	38%	○

Health Plan Stability Measures
Plan Performance by Measure

Practitioner Turnover PCP 2002 Results		
	2002	
Maryland HMO/POS Average	**8%**	
BlueChoice	3%	●
Coventry	7%	●
CIGNA	7%	⊙
PHN	8%	⊙
Aetna	8%	⊙
Delmarva	9%	⊙
M.D. IPA	9%	⊙
OCI	9%	○
Kaiser	11%	○

Health Plan Descriptive Information Measures
Plan Performance by Measure

PCP Board Certification 2002 Results		
	2002	
Maryland HMO/POS Average	84%	
PHN	94%	●
Coventry	90%	●
Kaiser	89%	●
CIGNA	83%	⊙
Delmarva	82%	⊙
M.D. IPA	82%	○
OCI	80%	○
Aetna	80%	○
BlueChoice	76%	○

OB/GYN Providers Board Certification 2002 Results		
	2002	
Maryland HMO/POS Average	83%	
PHN	95%	●
Coventry	91%	●
Kaiser	89%	●
M.D. IPA	82%	⊙
Delmarva	77%	⊙
OCI	80%	○
BlueChoice	80%	○
CIGNA	77%	○
Aetna	74%	○

Pediatrician Board Certification 2002 Results		
	2002	
Maryland HMO/POS Average	81%	
PHN	100%	●
Coventry	90%	●
Kaiser	88%	⊙
M.D. IPA	85%	⊙
OCI	85%	⊙
BlueChoice	82%	⊙
Delmarva	80%	⊙
CIGNA	67%	○
Aetna	53%	○

Other Board Certification 2002 Results		
	2002	
Maryland HMO/POS Average	84%	
PHN	100%	●
Delmarva	95%	●
Coventry	92%	●
Kaiser	87%	●
M.D. IPA	81%	○
OCI	81%	○
BlueChoice	78%	○
CIGNA	76%	○
Aetna	67%	○

PCP Residency Completion 2002 Results		
	2002	
Maryland HMO/POS Average	96%	
M.D. IPA	100%	●
OCI	100%	●
Coventry	100%	●
PHN	99%	●
Aetna	98%	●
CIGNA	98%	●
Delmarva	96%	⊙
Kaiser	95%	⊙
BlueChoice	77%	○

OB/GYN Providers Residency Completion 2002 Results		
	2002	
Maryland HMO/POS Average	97%	
Aetna	100%	●
Delmarva	100%	●
M.D. IPA	100%	●
OCI	100%	●
CIGNA	100%	●
PHN	99%	●
Coventry	99%	●
Kaiser	96%	⊙
BlueChoice	80%	○

Health Plan Descriptive Information Measures
Plan Performance by Measure

Pediatrician Residency Completion 2002 Results		
	2002	
Maryland HMO/POS Average	**96%**	
Aetna	100%	●
Delmarva	100%	●
M.D. IPA	100%	●
OCI	100%	●
PHN	100%	●
CIGNA	99%	●
Coventry	95%	⊙
Kaiser	92%	⊙
BlueChoice	82%	○

Other Residency Completion 2002 Results		
	2002	
Maryland HMO/POS Average	**96%**	
M.D. IPA	100%	●
OCI	100%	●
PHN	100%	●
Aetna	100%	●
CIGNA	99%	●
Coventry	97%	●
Delmarva	97%	⊙
Kaiser	93%	○
BlueChoice	78%	○

Use of Services Measures
Plan Performance by Measure

Well-Child Visits in the First 15 Months 2002 Results		
	2002	
Maryland HMO/POS Average	66%	
BlueChoice	79%	●
PHN	77%	●
Coventry	74%	●
M.D. IPA	70%	●
OCI	70%	●
CIGNA	67%	⊙
Kaiser	66%	⊙
Delmarva	48%	○
Aetna	47%	○

Well-Child Visits in the 3rd, 4th, 5th, 6th Years 2002 Results		
	2002	
Maryland HMO/POS Average	68%	
M.D. IPA	76%	●
PHN	75%	●
BlueChoice	73%	●
OCI	69%	⊙
Coventry	68%	⊙
Kaiser	67%	⊙
Aetna	62%	○
Delmarva	61%	○
CIGNA	59%	○

Well-Child Composite 2002 Results		
	2002	
Maryland HMO/POS Average	67%	
BlueChoice	76%	●
PHN	76%	●
M.D. IPA	73%	●
Coventry	71%	●
OCI	69%	●
Kaiser	67%	⊙
CIGNA	63%	○
Delmarva	55%	○
Aetna	54%	○

Adolescent Well-Care Visits 2002 Results		
	2002	
Maryland HMO/POS Average	37%	
PHN	45%	●
M.D. IPA	42%	●
OCI	40%	⊙
BlueChoice	38%	⊙
Delmarva	37%	⊙
Kaiser	34%	○
Coventry	34%	○
Aetna	33%	○
CIGNA	29%	○

APPENDIX B

METHODS FOR DATA ANALYSES

METHODS FOR DATA ANALYSES

Methodology to Compare Plan Performance

For each HEDIS measure, CAHPS® question, and CAHPS® composite, a score is computed for each plan, and the mean value is computed for all of the plans as a group. Each score or mean is expressed as a percentage with higher values usually representing more favorable performance.

Plan ratings for each measure are based on the difference between the plan score and the unweighted group mean. The statistical significance of each difference is determined by computing a 95% confidence interval (CI) around it. If the lower limit of the CI exceeds zero then the plan score is significantly above the mean. If the upper limit of the CI is less than zero then the plan score is significantly below the mean. Plans with scores significantly above or below the mean at the 95 percent significance level usually receive the highest and lowest designations respectively. All remaining plans receive the middle designation.

The specific formula for calculating the CI for each measure is as follows:

For a given HEDIS measure or CAHPS® individual question and plan k, let the difference d_k = plan k score – group mean. Then the formula for the 95% CI is $d_k \pm 1.96\sqrt{Var(d_k)}$

where $Var(d_k)$= Variance of d_k is estimated as

$$\frac{P(P-2)}{P^2} * \frac{p_k(1-p_k)}{n_k} + \frac{1}{P^2}\sum_{k=1}^{P}\frac{p_k(1-p_k)}{n_k}$$

and p_k = plan k score
P = total number of plans
n_k = the measure denominator for plan k

For a CAHPS® composite, the variance formula is modified by substituting the plan composite global proportion variance ($CGPV_k$) for the $p_k(1-p_k)/n_k$ terms where

$$CGPV_k = \frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

and $j = 1,\ldots,m$ questions in the composite measure
$i = 1,\ldots,n_j$ members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = plan mean for question j
N = members responding to at least one question in the composite.

Alternatively, the CI formula can be rearranged to compute the test statistic $\frac{d_k^2}{Var(d_k)}$.

For $d_j > 0$, the lower limit of the CI is > 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

For $d_j < 0$, the upper limit of the CI is < 0 if and only if $\frac{d_k^2}{Var(d_k)} > 1.96^2 = 3.84$.

Comparing Rates Across Years

For determining the statistical significance of the trend in a plan score between 2000 and 2002, first compute the difference in plan scores between the two years. This difference *d* can be written as $p_{2002} - p_{2000}$ where p_{200x} is the plan score for year 200x on a given measure. Then compute a 95% CI around the difference. If the lower limit of the CI is greater than zero than the trend is significantly upward. If the upper limit of the CI is less than zero then the trend is significantly downward.

The formula for the CI around *d* is: $d \pm 1.96\sqrt{Var(d)}$

where $Var(d) = \hat{p}(1-\hat{p})\left(\frac{1}{n_{2000}} + \frac{1}{n_{2002}}\right)$

and $\hat{p} = \frac{p_{2000}n_{2000} + p_{2002}n_{2002}}{n_{2000} + n_{2002}}$

and n_{200x} is the measure denominator for year 200x.

APPENDIX C

METHODOLOGY FOR AUDIT OF 2002 HEDIS RATES FOR MARYLAND HMOs & POS PLANS

THE HEDIS COMPLIANCE AUDIT

HealthcareData.com (HDC), the NCQA-licensed audit firm hired by the state, conducted a full audit of each Maryland commercial health plan as prescribed by *HEDIS 2002, Volume 5: Compliance Audit™: Standards, Policies and Procedures*, published by NCQA. In addition, the audit firm reviewed data MHCC required plans to report in 2002. A major objective of the Maryland audit is to determine the reasonableness and accuracy of how each plan collects and reports HEDIS data; one element of required performance reporting in Maryland. In addition to ensuring that the rates reported publicly are accurate and comparable, the audit also satisfies a requirement of health plan accreditation by NCQA. HDC provided each plan with an audit that met NCQA requirements while also providing information to plans that will help improve their operations and facilitate better performance reporting.

The audit is primarily intended to examine how plans collect and report HEDIS data. HEDIS is a standardized set of key performance measures designed to allow purchasers and consumers to have the information they need to reliably compare the performance of managed care plans. By using a standardized methodology to collect the data and to calculate the measures, consumers, government agencies, employers and health plans themselves can more accurately evaluate and trend plan performance and make comparisons among plans. HDC's audit, conducted by NCQA-certified auditors, focused on two areas in each health plan, specifically: (1) an assessment of overall information systems capabilities, and (2) an evaluation of the health plan's ability to comply with HEDIS specifications for individual measures.

The audit process itself was divided into three phases: (1) audit preparation, (2) on-site visit and (3) post on-site and reporting activities. During these three phases, HDC auditors focused on a number of performance areas – including information practices and control procedures, sampling methods, data integrity, analytic file production, algorithmic compliance with measurement specifications, reporting and documentation.

A detailed description of the well-defined phases of the audit appears in NCQA's *HEDIS 2002, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. The description includes an overview of the tasks within each phase of the audit.

Phase 1: Audit Preparation

The initial phase consisted of various supporting tasks or activities defined by NCQA. Activities performed included:

- providing the baseline assessment tool to health plans for completion;
- selecting mutually agreeable audit dates;
- certifying the CAHPS® sample frames;
- reviewing the completed Baseline Assessment Tool;
- selecting core measures;
- finalizing the audit team;

- requesting source code for measures outside of pre-certified software;
- developing a detailed agenda for the on-site audit;
- reviewing various vendor operations and processes; and
- conducting a pre-visit conference call to discuss outstanding issues.

A key activity critical to the success of the audit was each plan's completion of the Baseline Assessment Tool (BAT) in a timely manner and prior to the on-site visit, plus a thorough review of the completed tool by HDC auditors. The BAT is a comprehensive instrument designed by NCQA to collect information from the health plan regarding its structure, information collection and processing (e.g., claims/encounter processing, medical record review processes, membership data processes, provider data processes) and HEDIS reporting procedures (e.g., measure programming/determinations, reporting functions).

Another key task in the audit was the auditors' selection of a core set of measures for each plan. The minimum number of measures in each core set is fourteen measures distributed across six HEDIS domains. As required, the core set can be expanded based on findings and issues that surface during the on-site audit. Each auditor used a variety of criteria to select the core set, which includes but is not limited to the following:

- measures revised by NCQA from the prior year;
- new measures being reported;
- measures calculated by vendors or outside third parties;
- internal processes affecting data collection;
- issues identified from review of the BAT that could impact code development; and
- problems experienced by the plan in prior audits.

HDC auditors utilized the core set as a means of evaluating all of the measures within the various HEDIS domains. Findings from their review were then extrapolated to the full set of HEDIS measures in making a final determination of their reportability. Unless the plan used a pre-certified vendor to calculate its measures, all source code associated with a core set measure was reviewed. The distribution of measures across all domains appears in the table below:

Components of Measures for Minimum Core Set

Effectiveness of Care	4
Access/Availability of Care	2
Satisfaction With the Experience of Care	1
Health Plan Stability	2
Use of Services	4
Health Plan Descriptive Information	1

The audit included all additional measures that MHCC required commercial HMOs to report in 2002.

Source code review for measures in the core set started during Phase One with initial review of the source code associated with the CAHPS® sample frame programming.

Phase 2: On-Site Visit

During Phase 2 of the compliance audit, HDC auditors visited each plan. Only senior, experienced auditors were assigned to the audit and the on-site visit. The on-site portion was composed of a number of critical activities falling into two broad categories: (1) an assessment of compliance with NCQA's standards for information systems capabilities and (2) an evaluation of compliance with the HEDIS measure specifications.

(1) Information Systems (IS) Standards Assessment: During the IS assessment, HDC auditors determined the impact of various IS practices on the HEDIS reporting process. The key to accurate reporting is comprehensive and accurate data. The auditors did not attempt to evaluate the overall effectiveness of the health plan's management information systems; rather, they determined whether the health plan's automated systems, information management practices and data control procedures ensured that all information required for HEDIS reporting was adequately captured, translated, stored, analyzed and reported.

The activities of HDC auditors in this aspect of the audit consisted of the following:

- interviews of key plan representatives responsible for operations or departments supplying data used in HEDIS reporting;
- review of documentation relevant to the information system domains and, as needed, a demonstration of specific procedures;
- analysis of the documentation describing the operation of computer systems and computerized files via text, code, and flow charts;
- observation of operations which include those areas that use the information system resources while preparing data for the HEDIS report;
- verification that file contents were accurate;
- review of the oversight actions by the plan for all data received and transmitted; and
- evaluation of how data from the medical record review data abstraction process were integrated into the final measure calculations.

(2) HEDIS Measure Determination Standards: Each measure has a detailed set of specifications that describe both its purpose and method of calculation. In this activity, HDC auditors determined whether the processes used to produce each HEDIS measure complied with these HEDIS specifications and thus yielded "reportable" results. If issues or discrepancies were identified, the health plan was given the opportunity to make corrections and resubmit corrective code until the HDC auditors were satisfied that all specifications were met. To facilitate the process, HDC assigned one code reviewer exclusively to each health plan. In this audit component, auditors evaluated the following:

- identification of members for the eligible population (denominator) files, according to HEDIS specifications;

- determination of the extent to which sampling activities were performed according to HEDIS specifications;
- qualifying medical events (numerator) identification;
- determination of algorithmic compliance by ensuring that the computation of HEDIS rates or percentages, as well as other parameters, was done correctly;
- the documentation of data and processes;
- delegation and monitoring of activities performed by vendors; and
- assessment of software pre-certification results, as applicable.

Phase 3: Post On-Site and Reporting Activities

In Phase 3, HDC auditors worked closely with plan representatives to ensure that they understood all unresolved issues and deficiencies as well as the potential effects of these issues and deficiencies on HEDIS data collection and reporting. When appropriate, additional questions were presented to each plan about plan software, programming, manual processing, data input and output, and the effect of significant events, such as system conversion. All corrective and follow-up action and reporting were centrally coordinated and documented. Each plan was also given a final review and the opportunity to correct any unresolved items before a final reportability determination was issued on each HEDIS measures. Key activities accomplished during this phase were:

(1) Initial Report of Findings: Within 10 working days of the on-site visit, the HDC audit team prepared an initial report on their visit. The report was returned to the health plan and included:

- a detailed listing of any outstanding issues;
- a listing of all materials/documentation not yet received;
- an assessment of whether each measure tested met specific data requirements;
- a listing of all problem areas that required follow-up action before the final audit report was issued;
- potential problems with measure rate integrity; and
- notes about any measures which, based on current findings to this point, would not be reportable should no further action be taken to correct identified deficiencies.

(2) Medical Record Review Validation: In this portion of the audit, the HDC auditors completed their evaluation of the health plan's medical record review process. Prior to this portion, the auditor had previously reviewed all training materials and internal oversight policies established for medical record review. Then the auditor verified the accuracy of the health plan's findings in which a numerator positive event was identified, i.e., the plan's reviewer determined whether or not the criteria for the measure were met and the designated medical service was delivered. Each auditor selected two or more measures for each plan and requested 30 charts for each measure. All plans were found compliant for this portion of the audit.

(3) DST Review: The Data Submission Tool (DST) is used by the health plan to electronically record all HEDIS results and calculations that are submitted to NCQA and MHCC. Maryland-specific data were submitted on an MHCC-specific DST. The DST review consisted of two phases. First, the plan submitted the results to NCQA where the data is subjected to a series of rules and guidelines that helped to identify potential problem areas for correction. After passing this level of review, the health plan sent the DST to its auditor for review. The auditor compared the plan's results to establish NCQA benchmarks and compared the plan's results with its rates from the previous year. Rates that varied by 10% or more between years were flagged, as were rates below the 10th and above the 90th percentiles in comparison to NCQA benchmarks. Problems detected by the auditors were evaluated to determine whether additional analysis and review were necessary.

(4) Audit Designations: After reviewing all relevant documentation and processes, the HDC auditor issued a designation of *Report* or *Not Report* for each measure included in the audit. Determination for each measure was based upon the rationales described in the section below.

R = Report

"Report" designation indicates the measure was fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate. Under NCQA guidelines, it is possible for subcomponents of a measure to fail the audit and be designated "NR," without resulting in a NR rating for the entire measure. An example of this is would be if a rate for a specific vaccine like hepatitis was designated NR, but the measure childhood immunization, being a composite of many vaccines, was deemed to be "Reportable." A measure designation of "Report" may also be assigned where the denominator for the measure was too small to report a valid rate or where the plan did not offer a health benefit for the measure being reported. In these cases, the rate is designated in the Maryland publications as "**NA" (Not Available)** and the measure is "Reportable" with that designation.[1]

[1] Except in cases of very small plans, MHCC has found that NA ratings should not always be interpreted to mean that fewer than 30 members of an entire health plan met the criteria for a measure. With few exceptions, NA seem to denote a deficiency in the plan's data collection system, perhaps not identified during the audit, that does not allow it to accurately identify members who met criteria and may or may not have received the service being measured.

NR = Not Report In compliance with guidelines established by the State of Maryland, the "Not Report" designation for a measure indicates that the rate submitted by the plan did not pass the audit. In other words, the results produced by the plan were determined by the auditor to be significantly biased and therefore not reflective of the plan's true performance. NCQA has broader categories for the "NR" designation, but **in Maryland health plans cannot voluntarily choose to submit an "NR" designation in place of a rate. Health plans are required to report all HEDIS measures that are part of the state's mandated performance reporting process.**

HDC tasked all auditors to resolve issues and diligently work to ensure that all measures were reported and received, to the fullest extent possible under NCQA/MHCC guidelines, a "Report" designation from the audit. Several measures (e.g., Child CAHPS®, Management of Menopause) received a "Not Report" designation for all plans. These measures were not required by MHCC and were not calculated by most plans, and therefore the measures are not included in this report.

The Advising Smokers to Quit measure was not reported this year because NCQA reporting guidelines have been modified for that measure. Survey responses for the smoking measure now will be reported in 2003 as a moving average combining results from 2002 and 2003. As noted in this report, all required measures for all plans were designated as Report, with one exception. One plan was issued a "NR" for a portion of the HEDIS measure because the health plan had difficulty identifying the eligible member population in age group 5-9 for this measure. All MHCC-specific measures also received a "Report" designation. This was a significant improvement from the prior year.

(5) Audit Findings: HDC summarized its audit findings in a plan-specific Final Audit Report that was submitted to the plans and to MHCC. The report included recommendations for improvement and change in future audits. In reviewing the audit results as well as the chronological workload of the auditors, the performance of Maryland health plans continues to improve and all audit goals were accomplished.

APPENDIX D

METHODOLOGY FOR ADMINISTERING CAHPS® 2.0H SURVEY FOR MARYLAND HMOs & POS PLANS

METHODOLOGY FOR ADMINISTERING CAHPS® 2.0H SURVEY FOR MARYLAND HMOS & POS PLANS

Background

The survey instrument employed in 2002 was the Consumer Assessment of Health Plans study questionnaire and protocol (CAHPS® 2.0H). MHCC contracted with Market Facts, an NCQA certified CAHPS® vendor that specializes in health care and other consumer satisfaction surveys, to administer the survey to commercial HMOs in Maryland in 2002. Survey data collection began in early February 2002 and lasted into May 2002. Summary-level data files generated by NCQA were distributed in June to each of the plans to allow review of data prior to signing attestations. The plans and MHCC received this final report from Market Facts in July.

The CAHPS® 2.0H Survey

The adult commercial CAHPS® 2.0H survey is a member of a family of surveys that assess patient satisfaction with their experience of care. There are also CAHPS® 2.0H surveys for child commercial, adult Medicaid, and child Medicaid populations. The surveys were developed under the auspices of the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research).

AHRQ is the leading federal agency performing quality of care research, and has the responsibility to coordinate all federal quality improvement efforts and health services research. The survey was extensively tested before going into use in all fifty states and Puerto Rico. It has been translated into Spanish, Lebanese, Chinese, Arabic, and other languages. The version of the adult commercial survey, and particularly the survey protocol used here, was adopted by NCQA for accreditation purposes.

In total, the Maryland core CAHPS® 2.0H survey consists of 70 questions—10 of which are Maryland specific questions. The core of the survey is a set of 10 measures that are used to understand satisfaction with the experience with care. These include four ratings questions that reflect overall satisfaction and six composites that summarize responses in key areas. A description of how the composites are calculated is presented later in Results for several ratings questions and composites are presented in section five of this report.

One significant change to the core questions from the previous year was that the "does not apply" option was removed from question series that follow a "gatekeeper" question. The assumption for this change was that once a respondent answered no to the "gatekeeper" question they would not continue to respond with another answer, i.e., "does not apply," in the subsequent series.

The ratings items ask the respondent to rate their doctor, specialist, experience with all care, and their health plan on a 0 to 10 scale. Information regarding the ratings items is presented in this report as percents of people who chose each response option. Responses are also summarized in categories. The top category summarizes those that chose a 9 or 10 rating. The second category summarizes those that chose a 7 or 8 rating. For example, all respondents that chose to rate their physician 9 or 10 would be counted as belonging to the top category; those respondents rating their physician a 7 or 8 would be counted as belonging to the second category.

There are six composite scores that are generated from the individual respondent level data. The six composite scores are: claims processing, courteous and helpful office staff, customer service, getting care quickly, getting needed care, and how well doctors communicate. Results for questions about claims processing and courteousness of office staff are not included in this report.

Altogether, data and analysis for nine Adult samples were completed. The nine health plans were:

1.	Aetna	Combined HMO/POS
2.	BlueChoice	Combined HMO/POS
3.	CIGNA	Combined HMO/POS
4.	Coventry	Combined HMO/POS
5.	Delmarva	Combined HMO/POS
6.	Kaiser	HMO Only
7.	M.D. IPA	Combined HMO/POS
8.	OCI	Combined HMO/POS
9.	PHN	Combined HMO/POS

Survey Methods and Procedures

Sampling: Eligibility and Selection Procedures

The health plan members who were eligible for participation in the CAHPS® 2.0H adult commercial survey had to be 18 years of age or older as of December 31 of the measurement year (2001). They also had to be continuously enrolled in the commercial plan for at least 11 of the last 12 months of 2001. The samples submitted to Market Facts are sets of all eligible members – the relevant population. All health plans were required to have their sample audited by an NCQA certified auditor prior to sending to Market Facts. HealthcareData.com, L.L.C., the auditor contracted by the state, certified the samples.

After Market Facts received and checked the population sample from the health plans, the files were deduplicated to assure that no more than one member of a household would be selected for participation. Members were then randomly selected for participation. The standard sample size for 2002 administration (2001-measurement year) was 950. This was a decrease from the 1,500 standard sample size of the previous year. Aetna

oversampled because they were not able to purge their population sample files of all their disenrolled members in time to meet NCQA's data submission deadlines.

In order to reach the maximum number of selected members, the sample files were sent to a National Change of Address (NCOA) look up and telephone matching service. Updated addresses and phone numbers were merged into the sample files.

Survey Protocol

The CAHPS® 2.0H survey protocol used to generate the data summarized in this report uses a rigorous, multi-stage contact protocol. The protocol features a mixed-mode approach that consists of a four-wave mailing (two questionnaires and two reminder postcards) with telephone follow-up of at least three telephone attempts. This protocol is designed both to maximize response rates and to give different types of responders a chance to reply to the survey in a way that they find comfortable. For example, telephone responders are more likely to be younger, male, and healthier. Mail responders are more likely to be older, better educated, and less healthy. The option for a mail-only approach was available, but MHCC chose to use the mixed-mode approach.

One difference between this year's protocol and last year's protocol was the elimination of a pre-notification postcard from the standard protocol for administering HEDIS® surveys.

Table 1. Data Collection Protocol

Task	Date
Market Facts receives audited, eligible population sample files from health plans	January 2002
Market Facts draws samples	January 2002
Market Facts sends samples for NCOA and telephone look-up	January 2002
Mail first questionnaire and cover letter	February 15, 2002
Mail first reminder postcard	February 22, 2002
Mail second questionnaire and cover letter	March 22, 2002
Mail second reminder postcard	March 28, 2002
Initiate Computer Assisted Telephone Interviewing (CATI)	April 11, 2002
End CATI interviewing	May 5, 2002
Market Facts Processes data	May 2002
Market Facts submits member level data files to NCQA	May 24, 2002
Market Facts receives summary level data files from NCQA	June 2002 - July 2002
Market Facts sends member and summary level data files to health plans	By June 7, 2002
Health plans sign attestations for NCQA	June 15, 2002
Maryland plans receive final report from Market Facts	July 2002

Response Rates

As directed by NCQA, response rate is calculated by dividing the number of completed surveys by the number in the original sample, minus the ineligible respondents (completes/total sample - ineligibles). A survey is classified as a valid completion if the member appropriately responds to Question 1 and answers at least 80% of the survey questions (not including Advising Smokers to Quit or custom questions). Ineligible respondents are those that are no longer enrolled in the health plan, cannot respond to the survey in the language in which it is administered, are deceased, or are mentally or physically incapacitated. Please note that the response rate formula was revised for 2002.

This year the ineligible respondents category no longer includes the disposition "a missing or undeliverable address and a missing or invalid phone number" (Bad Ad/PH). Unlike previous years, the disposition (Bad Ad/PH) "is not subtracted from the denominator. This year's response rates are therefore not directly comparable to the response rates of past years because they are calculated differently. The effective result of this change is to lower overall response rates.

The goal of the CAHPS® protocol is designed to achieve a minimum 55% response rate. The selected sample size and protocol hope to achieve the minimum response rate and a minimum 411 completes, with 107 smokers or recent quitters who have seen a practitioner during the measurement year.

In 2002, the total Maryland response rate was 45.50% compared to 45.71% in 2001,higher than the national average response rate of 42%. For 2002, the plan with the highest response rate was 57.44% and the plan with the lowest response rate was 34.48%.